

THE AFFORDABLE CARE ACT: THE IMPACT OF
HEALTH INSURANCE REFORM ON HEALTH
CARE CONSUMERS

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

ON

EXAMINING THE AFFORDABLE CARE ACT, FOCUSING ON THE IMPACT
OF HEALTH INSURANCE REFORM ON HEALTH CARE CONSUMERS

JANUARY 27, 2011

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THE AFFORDABLE CARE ACT: THE IMPACT OF HEALTH INSURANCE REFORM ON HEALTH CARE CONSUMERS

THURSDAY, JANUARY 27, 2011

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m. in Room SD-430, Dirksen Senate Office Building, Hon. Tom Harkin, chairman of the committee, presiding.

Present: Senators Harkin, Bingaman, Murray, Reed, Sanders, Hagan, Franken, Bennet, Enzi, Burr, Isakson, McCain, and Roberts.

OPENING STATEMENT OF SENATOR HARKIN

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will please come to order.

Today we meet for the first in a series of hearings that this committee will hold on The Affordable Care Act; hearings that will focus not on the politics of Health Care Reform nor on the rhetoric that surrounds it, but rather on the tangible, positive impact that reform is having on Americans' lives. I think we can all agree that what this debate needs is more light and less heat.

To that end, today's hearing will focus on the benefits of health reform that Americans are experiencing right now; specifically, the bundle of significant consumer protections that went into effect last September, known as the Patient's Bill of Rights. These protections are a historic, long-awaited improvement in the quality and scope of health coverage for all Americans. Every American who pays a health insurance premium is now protected against some of the most egregious and abusive practices of the health insurance industry.

Put another way, thanks to health reform Americans now have protections that every Senator on this dais has had for many years.

Before the Affordable Care Act, nearly 102 million Americans were in health insurance policies with lifetime limits; and it was estimated that as many as 20,000 people annually could be denied coverage for care due to those limits.

And, surprisingly, people in danger of hitting a lifetime limit are seriously ill, and their benefits run out just when they need them the most.

The Affordable Care Act permanently eliminates all lifetime limits and phases out annual limits by 2014, providing economic and

health security for those who need coverage the most at critical times.

One of those folks, Lisa Grasshoff, is here today and will talk a bit later about how the act's ban on lifetime limits has helped her care for her son and strengthen her family's financial future.

As I'm sure the Secretary will discuss in her testimony, last week the Department of Health and Human Services released an important report analyzing preexisting health conditions. The report's findings are striking; up to 129 million nonelderly Americans have a preexisting condition, and millions more are likely to develop such a condition over the next 8 years. Before the Affordable Care Act these Americans faced denial of coverage, restriction of health benefits, or higher premiums as a result of their preexisting condition. Their ability to take a new job, start their own business or make other important life changes was limited. They were, in effect, locked into their original insurance coverage.

Because of health reform, insurance companies are now prohibited from restricting or denying coverage to children under 19 because of a preexisting condition, and in 2014 this protection will be extended to all Americans.

Between now and 2014, the law establishes an insurance plan in every State tailored specifically to adults with preexisting conditions who are currently uninsurable, offering coverage at standard market rates; thousands of people have enrolled and received coverage of life-saving services like chemotherapy.

Another element of the Patient's Bill of Rights is a requirement for every insurance plan to cover evidence-based preventive services that will head off many illnesses, addressing them in the nurse's office rather than in the emergency room.

The cost of preventable disease consumes 75 percent of health care spending annually; dollars that could be used to build roads, improve schools, create jobs.

The prevention investments in the law are down payments on the long-term project of transforming our current sick care system into a genuine health care system; and first dollar coverage of preventive services like mammograms and immunizations are a vital part of that.

Before the Affordable Care Act millions of young adults went without health insurance because their jobs didn't offer it or because they were ineligible for coverage on their parent's policy.

These young people, starting a new job or a new business—folks who don't have a lot of money—had to largely fend for themselves in a chaotic, unregulated market for individual coverage that charges high premiums for only modest benefits.

Now health reform allows these young people—more than 2 million of them—to stay on their parent's policy until age 26; this reform relieves young people of the burden of high health insurance costs.

We will learn more about this from one of our witnesses today, Emily Schlichting, a University of Nebraska student.

Finally, the Affordable Care Act puts an end to one of the most outrageous insurance company abuses, that's cancelling insurance coverage right when someone gets sick, and sometimes based on technical paperwork error; for example, a California insurer, using

computer programs, had a dedicated program to cancel policies of pregnant women and the chronically ill only because they submitted expensive claims.

Another insurance company started a fraud investigation into anyone who submitted a claim reaching a certain cost level, looking for reasons to cancel the policy; insurance companies were also paying bonuses to employees based on how many policies they canceled, and therefore, how much money they saved the company.

Health reform puts an end to that sorry state of affairs.

So, today we'll hear from public officials at both the State and Federal levels charged with implementing and overseeing the Affordable Care Act, as well as private citizens who will talk about how this has affected them.

Our first panel, of course, we welcome Secretary of Health and Human Services, Kathleen Sebelius to her first hearing of this New Congress.

In addition to expertly implementing the private insurance market reforms for folks, today I want to applaud the Secretary for her relentless and effective work in eliminating the waste, fraud and abuse in Medicare and Medicaid.

This week the department reported that it had recovered more than \$4 billion from perpetrators of fraud last year; the highest annual recovery ever.

Thank you very much, Madam Secretary.

The department released new rules authorized by the Affordable Care Act, giving it even more effective tools to detect and combat fraud.

Our second panel is comprised of Rhode Island Insurance Commissioner, Chris Koller, and three nongovernment witnesses, Lisa Grasshoff, Joe Olivo and Emily Schlichting.

As always, I am very pleased to be joined by our committee's Ranking Member, Senator Mike Enzi.

And, before I turn for an opening statement from Senator Enzi, one administrative matter: I request that the record remain open for 10 days from today for statements to be submitted to the record.

Senator Enzi.

STATEMENT OF SENATOR ENZI

Senator ENZI. Thank you, Mr. Chairman. I appreciate the Secretary being here today. I was very pleased at the State of the Union, that the President mentioned that there are flaws in the Health Care bill that need fixing. He specifically mentioned tort reform. Of course, a year and a half ago at the American Medical Association Convention, he promised that the Health Care bill would have tort reform and a permanent doc fix; neither of those things wound up in there.

Now, today's hearing is designed as another marketing tool for the health care plan. I don't think we can fault the millions that have been spent on the marketing—it's been voluminous, but it's the policy that's flawed, not the marketing plan.

It's easy to pick a few paragraphs out of a 2,700-page law to find a few provisions that are popular.

Apparently, the purpose of the hearing today is to identify those few issues in the new law that enjoy support; and that's often from both sides of the aisle.

Now, usually, a hearing is to seek solutions. Unfortunately, the reality is that Americans won't have the luxury of only abiding by their favorite paragraphs of the new law; Americans will be forced to comply with the entire law. That means, as a direct result of the new law, millions of Americans will see their health insurance premiums increase. Plans like Blue Shield of California have already announced premium increases of 59 percent; a portion of which they directly attribute to the mandates in the new law.

As a result of the new law, children in many States are not able to get child-only health plans. I recently got a letter from a disabled veteran in Wyoming. He wrote to me that because of the new law he can't get health insurance for his kids. He gets his health insurance care from the VA So, he doesn't need a family policy, he needs a policy for his two kids; but because of drafting errors in the new law, he's out of luck.

No health insurance plans in Wyoming are writing new child-only policies. I've asked my staff to look into this, and they found that to be the case in at least 19 other States. Because of the new law, kids are not able to get health insurance.

Another problem with the new law is that millions of seniors on Medicare will see their out-of-pocket costs go up and benefits go down, because more than \$500 billion was cut from Medicare and used to pay for a new entitlement program.

Because of the new law employers across the country will be forced to lay off workers and reduce wages as their health care costs continue to increase as a result of all the new taxes in the law that will increase their health care costs.

The new law also forces 16 million Americans into the Medicaid Program; one of the worst health care programs in the country, that provides some of the lowest-quality care; while at the same time, forcing cash-strapped States to pay an additional \$20 billion over the next 10 years to expand the program.

This is the reality that we face as a result of the new health care law; nothing in the testimony we will hear today is going to change it. That's why survey after survey shows that the American people reject the policy set forth in this new law. We recognize there are individuals who will benefit from a few of the provisions in the law; and, in fact, many of those provisions do enjoy bipartisan support.

There are many Senators, both Democrat and Republican, that support policies, like prohibiting rescissions and making it easier for parents to cover their children on their plans up to age 26. We could have easily enacted a bill last year that would have provided those protections; unfortunately, that's not what was done with the new health care law.

Instead, the new law will force Americans to buy the type of health insurance that Washington thinks they should have. Employers will be required to offer health insurance or pay \$52 billion in new taxes.

Americans will not have the luxury of picking which parts of the new law apply to them, but instead will have to comply with the

2,700 pages in new mandates, taxes, and limitations on their freedoms. And that doesn't even count the pages of new regulation.

There is a sign on the side of a building in Worland, WY that says: As regulations grow, freedoms die.

Madam Secretary, you have the unfortunate task of writing the hundreds of thousands of pages of regulations to implement an unpopular health care law that the American people reject. With each page you publish, you will be limiting the freedoms of everyday Americans; for example, the freedom of individuals to choose whether to spend their hard-earned dollars to pay their mortgage or to pay their health insurance premiums has vanished.

The Government now says: Americans have to pick health insurance. If you don't have health insurance, you're breaking the law, and you'll have to pay a fine.

Businesses that have more than 51 employees will not have the freedom to decide whether to increase an employee's pay or buy their employee health insurance. The new law says: If you don't provide health insurance you have to pay \$52 billion in new taxes.

The freedoms of businesses to make decisions about how to run their companies are disappearing. Americans who wish to pay lower health insurance premiums by picking a plan that has a higher deductible will no longer have this freedom. The new law decrees that Washington knows best.

The Administration will soon be publishing regulations capping the amount of out-of-pocket costs and limiting the deductible amount small businesses can offer their employees.

Madam Secretary, I don't envy you your job, and I do appreciate, though, that you're here today, and that you have been working on those regulations, and meeting a lot of the deadlines; and we will have the opportunity to ask some tough questions about the new law.

I do believe this is your first time to appear before this committee since your nomination hearing roughly 2 years ago; and to perform proper oversight, this committee will need to hear more from you; and I will ask you to reaffirm that commitment today.

I'm glad this committee will finally have the opportunity to ask you questions about the implementation of the new health care law which impacts $\frac{1}{6}$ of our Nation's economy. And, of course, I'm always interested in the donut-hole provision where PhRMA, by paying 50 percent of the cost to get people through the donut hole will then get 95 percent from taxpayers once Seniors are through the donut hole because we no longer give incentives for people to go to generics.

I have people from Wyoming talking to me about Medicare Advantage because their rates have gone up so much, or have completely been eliminated that they're losing a part of what they consider to be health care and—invaluable health care—and there's some animosity toward the AARP because they helped to do that, and they are the ones supplying the Medigap policy, which these people say they can't afford.

I believe that we can and should do better. I intend to focus on ways to eliminate the provisions in this new law that limit our basic freedoms. In their place I will work to enact reforms that will

focus on increasing consumer choices and decreasing health care costs.

We must make health care more affordable for both consumers and the Federal taxpayer.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Enzi.

Again, we have an exceptional group of witnesses today. I'd like to thank all of you for taking the time and energy for being here.

On our first panel, of course, is Secretary of Health and Human Services, Kathleen Sebelius; and we welcome her here, again, as Senator Enzi said, for her first appearance before this committee.

Secretary Sebelius was a leading voice involved during the passage of the Affordable Care Act. She is responsible for implementing many of the key provisions; and of course, we all know that prior to joining the Cabinet, Secretary Sebelius served first as the Kansas Insurance Commissioner; so she has a great deal of knowledge in that area; and then later, of course, as the Honorable Governor of the State of Kansas, where she worked to expand access to quality affordable health care, and fought to protect consumers.

So, Madam Secretary, thank you for your hard work. Thank you for sharing your knowledge with the committee today. I commend you for your work on this important issue; your statement will be made a part of the record in its entirety. Please proceed as you so desire.

**STATEMENT OF HON. KATHLEEN SEBELIUS, SECRETARY,
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES,
WASHINGTON, DC**

Secretary SEBELIUS. Thank you very much, Mr. Chairman. It's nice to have a chance to visit with the HELP Committee on this important issue, and I want to thank Chairman Harkin, and Senator Enzi, and members of the committee for the opportunity to discuss the implementation of the Affordable Care Act, and talk a little bit about the enormous difference it's already making in the lives of Americans since it was passed.

As you know, in the framework of the bill, over the last 10 months, our department has worked closely with two other departments; with Treasury and Secretary Tim Geithner and with Labor and Secretary Hilda L. Solis. But, we've also been working very closely with governors across the country; with my former colleagues, State insurance commissioners, with health care providers, doctors and nurses, with consumer advocates, employers and other stake-holders, to deliver the key benefits that have already become available to the people of America.

We've met deadlines, we've established strong, working partnerships and begun laying the groundwork for the additional reforms that take place in the years to come; and in that time, I've had the chance to see the new law through the eyes of people it helps every day.

Mr. Chairman, you've already referenced the new Patient's Bill of Rights. And because of the enactment of those provisions, millions of Americans don't have to worry about losing their health insurance when they need it most; many of the worst abuses of the

insurance industry, like unfair and arbitrary rescission practices and lifetime dollar limits on benefits have now been brought to an end.

In addition, the new law begins to free as many as 129 million Americans with preexisting health conditions from the fear of discrimination by insurance companies.

Starting this year, it did prevent insurers from denying coverage to children because of a disability or illness; and in 2014 all Americans will be free from discrimination by companies based on their health status.

The law is also beginning to slow down the rising health insurance cost for families and small business owners; the new resources for States to review questionable premium hikes; the new regulations that limit the amount of premium dollars that insurers can spend on marketing and CEO bonuses.

Beginning in 2014 individuals, families, and small businesses will be able to pool their purchasing power and negotiate lower rates in new health insurance exchanges, which many States are already working on, to design and implement.

I've also seen how the new law is impacting America's business owners. Over 5,000 businesses, State and local governments, and unions are already using new funds to help maintain coverage for a very vulnerable population—folks between the age of 55 and 64 and their families, the so-called early retirees. Around 4 million small business owners are now eligible for tax credits to help them provide insurance for their employees. Thanks to the new law, seniors and those Americans with disabilities enjoy a stronger and more sustainable Medicare.

We've sent over 3 million checks to those who fell into the donut hole last year, and they've received a one-time \$250 rebate check. This year, for those who reach the donut hole coverage in 2011, they will begin to receive a 50 percent discount on the covered name-brand prescription drugs; and over time, that donut hole closes altogether.

Medicare beneficiaries are now receiving critical preventive services and an annual wellness visit which has been added to their guaranteed benefits.

So, in addition to giving Americans more control over their health care, the new law is strengthening our economy; just recently, the Congressional Budget Office reiterated their numbers, that the new law will reduce the Federal deficit by \$230 billion over the next decade, and over a trillion dollars in the following decade.

Now, on Tuesday night, President Obama laid out a vision for how America can win the future by building a foundation for long-term growth that allows families and business owners to thrive.

Improving our health care system is vital to making that vision a reality; and the Affordable Care Act is an essential component to this goal.

By freeing families from the worst insurance company abuses, freeing entrepreneurs to start new businesses without worrying about losing their coverage, and freeing all of us from the burden of skyrocketing health care costs that make it hard for families to

pay their bills, the law allows American companies to compete and allows the Federal Government to bring down the deficit.

Since March of last year our department has focused on working with Congress and our partners across the country to implement the law quickly and effectively.

In the coming months, I look forward to working with all of you to continue those efforts and to make sure that Americans can take full advantage of all that the law has to offer.

Again, I thank you for this opportunity, and look forward to our discussion.

[The prepared statement of Secretary Sebelius follows:]

PREPARED STATEMENT OF KATHLEEN SEBELIUS

SUMMARY

Over the last 10 months, the Department of Health and Human Services has worked closely with the Departments of Treasury and Labor; Governors and State insurance commissioners; doctors, nurses and other health care providers; consumer advocates; employers; insurers; and other stakeholders to deliver many of the law's key benefits to the American people.

We've established a Patients' Bill of Rights to protect families from many of the worst insurance abuses including rescissions and lifetime dollar limits on care.

We've also begun to free as many as 129 million Americans from discrimination based on preexisting conditions. Today, it's illegal to deny coverage to children because of a preexisting health condition. In 2014, discrimination based on any individual's health history will be outlawed.

The law is bringing down premiums for consumers by limiting the amount of premiums insurers may spend on administrative costs and by giving States resources to beef up their rate review processes. In 2014, State-based Exchanges will bring down premiums further by giving individuals and small business owners the ability to pool their purchasing power to negotiate lower premiums.

There are other benefits for America's businesses as well. Over 5,000 businesses, State and local governments and unions are using funds from the Affordable Care Act to maintain coverage for pre-Medicare retirees and their families. Around 4 million small businesses may be eligible for a tax credit to help them provide health insurance for their employees.

Thanks to the law, seniors are gaining a stronger and more sustainable Medicare. Over 3 million seniors have already received one-time \$250 donut-hole rebate checks. This year, seniors in the donut hole will receive 50 percent discounts on covered brand name prescription drugs, and others will have access to many important preventive care services for free.

The law is a key part of the Administration's effort to win the future by out-innovating, out-educating and out-building the rest of the world. It gives Americans more freedom in their health care choices, from greater freedom to change jobs or start a business without worry that they'll lose coverage to greater freedom from skyrocketing premiums.

It also puts our budget on a more sustainable path by lowering the deficit by \$230 billion over the next decade and by over \$1 trillion by the end of the following decade.

Since March of last year, our Department has focused on working with Congress and our partners across the country to implement this law quickly and effectively. In the coming months, we look forward to working with all of you to continue that work and make sure that Americans can take full advantage of all that the law has to offer.

Chairman Harkin, Ranking Member Enzi, and members of the committee, thank you for the opportunity to discuss our department's implementation of the Affordable Care Act and the enormous difference it has made in the lives of Americans since it was passed.

Over the last 10 months, our department has worked closely with the Departments of Treasury and Labor, with Governors and State Insurance Commissioners, with doctors, nurses, other health care providers, consumer advocates, employers, insurers, and other stakeholders to deliver many of the law's key benefits to the American people: from establishing a new Patients' Bill of Rights that protects fami-

lies from the worst insurance company abuses, to sending more than 3 million \$250 checks to seniors and other beneficiaries in the Medicare Part D coverage gap, from making health insurance tax credits available to up to 4 million small businesses, to new reforms that keep premiums down by bringing transparency and accountability to our health insurance markets.

We have met deadlines, established strong working partnerships, and begun laying the groundwork for reforms that will take effect in the years to come.

In the last year, I've also gotten the chance to see this new law through the eyes of the people it helps every day. From the people I've talked to around the country, and the letters I get every day, I've learned firsthand how the law is giving Americans more freedom in their health care choices and more security in their coverage.

It's making a difference for people like Ralph Byrd from Phoenix. His twins have a condition called Spinal Muscular Atrophy that requires expensive treatments and a constant need for care. Ralph had health insurance but worried that the cost of care for his children would quickly reach the lifetime dollar limit on his plan.

Thanks to the new law, Ralph's family and countless others no longer have to worry about losing their health insurance when they need it most. In September, the Patients' Bill of Rights began to put an end to the worst abuses of the insurance industry, including the imposition of lifetime limits. It also put an end to unfair and arbitrary rescission practices and began to phase out annual dollar limits. It puts an end under most plans to outrageous fees you could be charged for going to the nearest emergency room. It allows parents to keep their children on family plans in most cases up to age 26.

By holding insurers accountable, the new law frees Americans from the worry that their benefits will be unfairly taken away or capped. It has given millions of families peace of mind.

At the same time, the new law begins to free Americans from the cruel practice of discrimination based on preexisting conditions.

In September, I met Gail O'Brien from Keene, NH. The previous March, Gail, who was uninsured, was diagnosed with non-Hodgkins Lymphoma. When she tried to get coverage she was declined because of her condition or offered coverage at an unaffordable rate. She faced the kind of decision that, unfortunately, millions of other Americans have faced over the last few years. Should she pay for health care or pay for her son's college education? Thanks to the new law, Gail was able to get coverage through the Preexisting Condition Insurance Plan created in each State by the new law. As a result, she has been able to get her treatments and is responding very well.

Today, Gail is just one of thousands of Americans who had previously been locked out of the health insurance market but now have coverage thanks to the new law. Even more significant, insurers are no longer allowed to deny coverage to children because of a preexisting health condition. In 2014, any kind of discrimination based on your health history will be outlawed. That's a day we will all celebrate.

Almost every family in America will benefit from this protection. According to a report our department released last week, as many as 129 million Americans—or nearly one in two people under the age of 65—may have a health condition that makes them vulnerable to insurance company discrimination today. Things as big as being a cancer survivor or as small as treating high blood pressure were enough to catch insurers' attention. And we know that they did not hesitate to use this power.

The new law is freeing these 129 million Americans from the worry that if they change jobs, retire, get divorced, or otherwise need individual market insurance, they'll be shut out of health insurance or denied the coverage they need.

We also need to make sure that coverage is affordable for individuals, families, and businesses. Already, provisions of the Affordable Care Act are helping to keep premium increases down by demanding transparency and accountability from the insurance industry. For too long, it has been a common occurrence for someone to open up their mail and find a 25 percent premium increase from their insurer with little explanation and no recourse.

That's changing under the new health care law. States are our frontline defense to prevent unreasonable premium increases. As a former State insurance commissioner, I am pleased by the State-focused approach the law takes to premium review. We are providing States with resources to help them beef up their rate review processes, including the ability to hire actuaries to perform the necessary analysis of rate proposals. In 2010, we provided the first round of what will eventually be \$250 million in funding to strengthen States' ability to review and reject unreasonable rate hikes. Over the last year, States from California to Connecticut have shown that vigorous oversight can be very effective at stopping unjustified premium increases. We also have proposed a system for transparency and consistent, reviews

of any premium increase over 10 percent in 2011 to identify any that are unreasonable.

In addition, for the first time, insurers will be held accountable for the way they spend consumer premiums. The new medical loss ratio regulations released last year implement the statutory requirement that insurers spend 80 to 85 percent of premium dollars on health care and quality improvement efforts instead of marketing and CEO bonuses. Those who don't meet the standard will have two choices: reduce premiums or send rebates to their customers. We are already seeing indications that these policies are causing insurance companies to think twice about their premium increases and, in some cases, reducing the size of their annual updates.

This is just the start of how the law will keep down premiums. In 2014, individuals, families, and many small businesses will be eligible for tax credits to help them afford health coverage purchased through the new Exchanges. They'll be able to pool their resources in new State-based health Exchanges to negotiate lower rates. We estimate that a family of four earning \$55,000 a year will save nearly \$6,000 each year as a result of these tax credits. A single mother with an income of \$33,000 will save nearly \$10,000, putting coverage within reach for the first time for these vulnerable families. The nonpartisan Congressional Budget Office estimates that small businesses will be able to purchase coverage in the Exchanges at a significant savings than what they are paying now, because of the larger risk pools and streamlined administrative costs. Large employers are also benefiting.

Creation of State-based health insurance Exchanges is a central component of the Affordable Care Act and a concept that has a long history of bipartisan support. Under the act, States have until 2014 to establish Exchanges for their citizens. As part of our partnership with the States, we are again providing resources to help them get these Exchanges up and running on time. We have provided Exchange Planning Grants to 48 States plus the District of Columbia and just last week we announced the availability of funds for States to begin the work to establish Exchanges. We will continue to work closely with governors, State regulators, and legislators to provide them with information and resources to complete this critical work on time.

The law also invests in improving Americans' access to care through \$11 billion in funding for community health centers to increase services, improve facilities and train and support more health care professionals to work in the areas they are needed most.

I've also seen how the new law is helping America's businesses. Under the new law, more than 5,000 businesses, local governments, and unions have signed up for a new program that helps them maintain coverage for retired workers who are not yet eligible for Medicare.

The California Public Employees Retiree System for example reports that by factoring the new program into its 2011 health plans, it was able to provide approximately \$200 million in premium savings to 115,000 early retirees and their families.

We have also notified more than 4 million small businesses and non-profits that they may be eligible for a tax credit this year to help them provide health insurance for their employees. We have already seen these credits working. After years of dropping coverage, we have seen the trend start to reverse thanks to the law.

For example, Blue Cross Blue Shield of Kansas City recently reported that after letting local businesses know about the new tax credit, they enrolled more than 9,000 new members covered by 400 new employers, more than a third of which had not previously offered coverage. On behalf of the Business Round Table, Hewitt analyzed the cost containment policies in the law and found that large employers could save up to \$3,000 per employee by 2019. Thanks to the new law, America's businesses are getting more freedom from soaring costs that made it hard for them to compete and keep their best employees.

The Affordable Care Act is also making Medicare stronger and more sustainable. Last week, we sent out our three millionth \$250 rebate check to help seniors and other beneficiaries who reached the Medicare Part D prescription drug benefit gap in 2010. Several of these seniors have written to me to say how helpful these checks were, including one couple from Minnesota who stapled their receipt to the card, showing how they spent the money at their local WalMart.

This year, seniors are getting more benefits. Those who reach the donut hole will receive a 50 percent discount on covered brand-name drugs while in the donut hole, the first step toward closing the donut hole by the end of the decade. Medicare beneficiaries will be eligible to receive recommended preventive services such as mammograms and most cancer screenings at no additional charge as well as free annual wellness visits.

In addition to giving Americans more control over their health care, the new law is strengthening our economy. More than 1 million new private sector jobs have

been created since the law passed and the health sector is one of the fastest growing parts of our economy. The Congressional Budget Office has said that the law will reduce our Federal deficit by \$230 billion over the next decade and by over \$1 trillion by the end of the following decade.

I have personally seen the difference this law will make and in just a few minutes, you'll hear more about how the law is making it easier for Americans to get the health care they need. This law is not just words on a page to be debated. There are names and faces that go along with this law. We are moving forward with real rights and reforms that are improving people's lives every day.

That's why last week's vote in the House to repeal this law was unfortunate. At a time when there is so much more important work to be done to rebuild our economy, we can't afford to take these benefits away from families, bring back all the worst practices of the insurance industry, raise premiums for families, increase health costs for businesses, and add \$1 trillion to the deficit by the end of the next decade.

Since March of last year, our department has focused on working with Congress and our partners across the country to implement this law quickly and effectively. In the coming months, I look forward to working with all of you to continue that work and make sure that Americans can take full advantage of all that the law has to offer. Thank you for your time.

The CHAIRMAN. Thank you, Madam Secretary.

We'll start our round of questions per agreement between the Ranking Member and myself earlier on; the order will be, The Chair, Ranking Member and then Senators in order of appearance; and my staff has written this, so it will be Senator McCain, Senator Franken, Senator Bingaman, Senator Bennet, Senator Roberts, Senator Reed, Senator Burr, Senator Isakson, Senator Sanders in that order.

Madam Secretary, getting to this child-only issue, could you describe the new protections that the Health Reform bill provides to children in the private market, and how that differs from the status quo before the Affordable Care Act was passed?

Secretary SEBELIUS. Mr. Chairman, before the Affordable Care Act, what a number of companies did is offer child-only policies, but eliminated any child with a preexisting health condition. So, the parents who really desperately needed coverage for their children with anything from asthma to diabetes to a cancer survivor, were blocked from getting coverage.

The Affordable Care Act says that if you are going to offer child-only policies that it must be open to all children. No longer can you only offer policies to children who don't have a health condition that may require them to have health insurance—what we have found companies doing is—some companies may be changing the kind of policy offerings. What most companies are doing are keeping in place their coverage for children like those referred to by Senator Enzi, and are selecting whether or not to offer policies going forward, prospective policies.

A number of States have taken action—I think 19 or 20 so far—to say companies who want to offer policies to children must offer them across the board, feeling that the discrimination against children with preexisting health conditions is the worst of all worries for parents; and particularly when you have a sick child, to not be able to find affordable coverage is just untenable.

Children are also eligible for the new high-risk insurance pools that are run in States across the country, in addition to the private health market.

The CHAIRMAN. So, it's kind of the same situation that we experience in other areas of insurance, that, if you're really healthy you can get a health insurance plan.

Secretary SEBELIUS. If you promise not to get sick.

The CHAIRMAN. That's right. And if you have no preexisting conditions.

One other thing that I wanted to just ask is: The first dollar coverage for proven cost-effective, preventive services. As you know, that's something that I worked very hard on with others to get into this bill. Senator Burr was also very active on that, to focus on preventive measures. So that has also started.

I just wanted to again ask you how the act's mandated coverage of these services are affecting Americans' health, and basically, how the provision is being implemented on the preventive end right now. How's that being implemented right now?

Secretary SEBELIUS. Mister Chairman, I know that prevention efforts are an area where you have spent a lot of time and energy over the years, and one that I think has the potential of yielding huge results in terms of not only lowering overall health costs—as you say, 75 cents of every dollar is spent on chronic diseases, most of which are preventable—but also on a healthier population, a healthier workforce. So the new law has a couple of provisions: Medicare beneficiaries now have eligibility for mammograms and cancer screenings, a variety of preventive coverage without co-pays; and that's a big step forward in terms of taking down a cost barrier. In new plans offered, beginning after January 1, 2011, the private insurers will also offer preventive services that are covering a wide range of care without co-pays, to encourage, again, people to have regular checkups, get screenings, find problems much before they get to be acute issues, and deal with them in a much more cost-effective and, frankly, life-saving strategy before people get acutely ill and spend that time in hospitals, or in a condition where their lifespan is reduced and their health costs skyrocket.

The CHAIRMAN. Just very simply, do you feel that the department has the wherewithal to implement this right now; in other words, to really implement these provisions?

Secretary SEBELIUS. We are finding that, yes, as we go forward we are moving ahead and those policies are becoming effective.

The CHAIRMAN. I appreciate that. Thank you, Madam Secretary.

Secretary SEBELIUS. Yes.

The CHAIRMAN. Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman.

I want to go back to the child-only plans question a little bit, because we did take a look and found that there are at least 20 States where you can't buy child-only insurance anymore. If they already have it, they can keep it, but there's not any new policies being issued, and consequently, they're getting out of that market.

So, for parents like the disabled veteran in Wyoming that I mentioned in my opening statement, who needs to buy a plan, it's absolutely devastating. The outcome's unfortunately predictable as a result of the drafting; which allows a person to buy a policy on their way to the emergency room, and so there's some incorrect drafting and incorrect implementation.

Do you have any specific steps that you're going to take to fix the problem in those 20 States? Does Congress need to change the law?

Secretary SEBELIUS. Senator, we have done a lot of outreach with insurers across the country, and while there was an initial flurry of announcements, many insurance companies are reconsidering their initial plans to leave the marketplace.

I would suggest it was, in some cases, a pretty cynical notion that you would only insure as a health insurer, children without a preexisting health condition and keep those policies in place.

Parent's coverage is often available to many of the children who had child-only policies. We are finding that a lot of children are being insured again, through their parent's coverage, which has now been extended, as you know, to the age of 26, which has been a huge boom to a lot of families.

A number of children are also eligible for CHIP coverage and the new high-risk plan; so there are a variety of strategies in place to make sure that children have coverage. And we are continuing to work closely with insurance companies to help rethink the strategies between now and 2014. In 2014 there won't any longer be any barriers for anyone with a preexisting condition to have coverage. The child-only provisions kicked in, initially, this year.

Senator ENZI. So, you're saying there's no need for changes.

Secretary SEBELIUS. Senator, we will continue to look at the situation, particularly in States like Wyoming, if all the companies have moved out. I think it's untenable for parents not to have coverage, but I would suggest—I would hope that we could call on the companies who have made ample profits selling child-only policies to children who were not ill or had any preexisting condition to reconsider their efforts to leave the market; and a whole series of companies have, indeed, done that.

Senator ENZI. I would hope that we could make a fix in the law as well, so that people don't just buy their insurance on their way to the emergency room.

Yesterday, before the House Budget Committee, your Department's Chief Medicare Actuary, Richard Foster, testified that the new health care law will not hold down health care costs, and will not allow everyone to keep their current coverage.

Specifically when asked about the claim that the law reduces costs, Mr. Foster described it as false more so than true. Regarding the claim that people would be allowed to keep their current coverage, Mr. Foster described that claim as not true in all cases.

Is Mr. Foster wrong in his analysis? What information do you have to counter the detailed analysis he's done of the new law?

Secretary SEBELIUS. Senator, I have not had a chance to thoroughly analyze Mr. Foster's testimony. I know in the past when he has testified about the quarter of a trillion dollars in deficit reduction, he has speculated that if, indeed, the law is changed somewhere in the next 10 years, and if, indeed, Congress does not implement the law as is, then the quarter of a trillion dollars savings would not be realized.

We are standing by the Congressional Budget Office analysis, your Budget Office analysis, which has had a series of numbers about not only the impact on families, and says that costs will go

down, the impact on individual business owners' premiums, which say that costs will go down, but also the impact on the deficit.

And the Congressional Budget Office again says that costs will go down.

Senator ENZI. You and I know that the Congressional Budget Office is limited by what documents we give them to make their analysis on. The doc fix alone creates a substantial loss, but they weren't allowed to consider that in the analysis.

Now, in your testimony you noted the new laws strengthen the economy.

Oh, my time has expired. I will be submitting some questions if we don't go additional rounds.

The CHAIRMAN. OK, thank you. Thank you, Senator.

Senator McCain.

STATEMENT OF SENATOR MCCAIN

Senator MCCAIN. Thank you, Mr. Chairman.

Madam Secretary, the President said on Tuesday night, that he is in favor of repealing the 1099 Small Business tax increase from the Health Reform Law, and also believes that medical malpractice should be an issue that we should be addressing; do you agree with the President?

Secretary SEBELIUS. Yes, sir.

Senator MCCAIN. Would you submit, perhaps for the record, some idea of what the parameters of medical malpractice reform might be—suggestions that the department might have?

Secretary SEBELIUS. Senator, as you know, the department has had authority for—

Senator MCCAIN. The question is, would you submit for the record—

Secretary SEBELIUS. Would I submit them? Sure.

Senator MCCAIN. Thank you, very much, since we tried repeatedly over a year to get something addressing this issue in the 2,700-page health reform document, some action on what most experts agree contributes sometimes 20, 30 percent to the additional costs of health care.

You have granted over 700 waivers. Now, for employers and union plans from the, "annual benefit limit restrictions and health reform bill," why not make those permanent?

Secretary SEBELIUS. Senator, the goal of the law in the area of the annual limit benefit granted our department the discretion to look at situations which would cause, not only market disruption, but a dramatic increase in premiums; and what we have done, on a case-by-case basis, is receive information particularly about the so-called mini-med plans that are employer-based coverage throughout the country, and grant waivers where the employer indicated that there would be—

Senator MCCAIN. I understand—

Secretary SEBELIUS [continuing]. An enormous rate increase.

Senator MCCAIN [continuing]. How it works. I'm asking why you wouldn't want to make them permanent.

Secretary SEBELIUS. That isn't—

Senator MCCAIN. I appreciate if you would make your answers short.

Secretary SEBELIUS. Why wouldn't we want to make them permanent?

Senator McCAIN. Yes.

Secretary SEBELIUS. We're taking a look at the marketplace; they have assured us that they can gradually phase into——

Senator McCAIN. They have assured you.

Secretary SEBELIUS [continuing]. The annual limit that——

Senator McCAIN. They've assured you of that.

Secretary SEBELIUS. That's my understanding yes, sir.

Senator McCAIN. Thank you. As you know, the States are having great difficulty with their budgets, and there's some conversations about some States even having to go into some kind of bankruptcy, etc; and there are a number of States that have great difficulty in complying with the act, as you know.

In my home State of Arizona, we are facing a serious budget crisis. Our governor has written you a letter asking for a waiver. She's asking for your assistance in providing Arizona with a waiver from the maintenance of effort requirements of the Patient Protection and Affordable Care Act.

She goes on to say:

"I'm respectfully requesting that Arizona be allowed to reduce its Medicaid eligibility for certain nondisabled adults in order to preserve its underlying Medicaid Program."

Would you give serious consideration to the governor, and I'm sure other governors' request that States be able to exercise the flexibility that they need to meet their compelling budget requirements, and probably know best in the view of many of us, how to provide the best health care at the least possible cost for our constituents?

Secretary SEBELIUS. Senator, we're working very closely with governors across the country. I just received, yesterday, Governor Brewer's request, which we are taking a very careful look at; and also taking a very careful look at the law.

I can tell you that we are actively working with States around the country, with new governors, particularly, about the flexibility that they have; many of them aren't aware of the wide range of flexibility that they have to have cost savings in their Medicaid Programs; and we are actively working to provide teams of folks to go through the potential cost savings that other States have already implemented.

Senator McCAIN. I'm told that you have given a full waiver to three States; is that correct?

Secretary SEBELIUS. Not of the maintenance of effort, no, sir.

Senator McCAIN. I see, but you——

Secretary SEBELIUS. That has not ever even been raised before.

Senator McCAIN. I see. Thank you.

Again, Senator Enzi raised this, but something we all knew about CBO, garbage in, garbage out; but the person who we give the responsibilities, Medicare's independent economic expert, said that both assertions, that the cost will be brought down and let people keep their current health insurance, if they like it, he strongly disagrees.

I, of course, disagree, since there's 300,000 citizens in my State on Medicare Advantage, and there's no doubt that their benefits under that program will be significantly changed, if not eliminated.

I see my time has expired.

I look forward, Madam Secretary, on this issue of medical malpractice reform. The President told the American people Tuesday night that he recognizes that this is an issue that needs to be addressed.

We're going to find out whether the trial lawyers run this place or whether the American people, and affordable health care is reachable for them, because without medical malpractice reform it makes that issue, if not impossible, certainly extremely difficult; and we look forward to hearing your proposals as to how we can implement such as has been implemented in the State of Texas.

I thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

All right, next we'll turn to Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Thank you, Mr. Chairman. Speaking of the State of Texas, just to pick up from Senator McCain, my understanding is that the State of Texas order has this pretty dramatic tort reform. Health care there is much, much more expensive than it is in my State of Minnesota; is that correct?

Secretary SEBELIUS. I think that is correct, Senator.

Senator FRANKEN. I want to address the Ranking Member who said that there's just like a few paragraphs that people like in the bill, and that's what we keep talking about.

That is what I heard from the Ranking Member. I think if you go back and look at your opening statement, you'll see that, that that's what you said was in the marketing.

One of those paragraphs I would think that people do like, is getting rid of preexisting conditions as a reason to discriminate against a child or a patient; right? That's pretty popular; isn't it?

Secretary SEBELIUS. I think it's very popular with the American public, yes, sir.

Senator FRANKEN. OK, and then the Ranking Member talked about the ability to buy a policy on the way to the emergency room. Now, I've heard that, and what that is about is, well, if you have a preexisting condition you don't have to buy a policy until you get sick; that's what that characterization is; isn't it? I mean, is that your understanding of it?

Secretary SEBELIUS. I think that's what the Senator is referring to; that you could opt in and out of the market and only purchase coverage when you were sick.

Senator FRANKEN. So, isn't that the reason for the mandate? So, in other words, when I hear my friends who are opposed to this reform say, "Well, we really like the nondiscrimination against people with preexisting conditions, but then you can buy a health policy on the way to the emergency room"; well, that's why you have the mandate, isn't it?

Secretary SEBELIUS. The idea is to have a stable insurance pool, and to pool risk. As a former regulator, that's important to have folks who have coverage; and some use it and some are not using

it simultaneously. It would be like buying car insurance after you've had the wreck.

Senator FRANKEN. Right. So, if you think of health care reform as a three-legged stool—tell me if you agree with this analysis: First leg is, you can't discriminate against people with a pre-existing condition; and I hear everyone say that they want that; the second part is that since that means that you could buy an insurance policy on the way to the emergency room, you need a mandate, so that everyone has insurance, so you can't buy an insurance policy on the way to the emergency room, everyone would have it; right?

The third part is subsidizing; people can't afford it, and that's why we have a sliding scale up to 400 percent of poverty; isn't that correct? Isn't that a good analysis of what comprehensive health care reform is?

Secretary SEBELIUS. I think if you look at the parts of the market that don't function very well right now—for individuals buying coverage and for a lot of the small business owners—that having a much larger purchasing pool, having more people involved, eliminating the preexisting condition limitation, and then having everybody in, is certainly the way to stabilize the private insurance market.

As you know, that was a discussion that the insurers had; and since this plan is built around the private insurers' market, it adopts that strategy. You can get rid of the preexisting condition if everyone is in the pool.

Senator FRANKEN. Exactly. OK, so I think this is really a discussion about a comprehensive health care reform, and not just cherry picking certain paragraphs.

I wanted to ask you about the medical loss ratio and the implementation of that. As you know, I fought for that, which basically says that insurance companies that have large group policies have to use 85 percent of the premiums that they get on actual health care; 15 percent can go to marketing and administration and profits, and 80 percent if it's an individual or a small group.

Can you tell me a little bit about the implementation of this provision?

Secretary SEBELIUS. Senator, the provision has just been outlined. As you know, the Congress in the Affordable Care Act, directed the Nation's insurance commissioners, who are elected and appointed across the country, and who regulate the private market, to recommend a policy to us about the medical loss ratio provision, which you've just outlined.

They had a unanimous recommendation about what were the categories of health costs that should be included as medical costs, what should be outside, and how it should be implemented. We turned around and adopted their recommendations, and that is, really, the policy that's in place.

This year, for 2011, data will be collected by our department about companies meeting that ratio. At the end of the day, companies who fail to meet the ratio will owe their policy holders a rebate; but the rebates do not start until 2012, until data has been collected.

Senator FRANKEN. Thank you. My time is finished.

Thank you, Mr. Chair.
 The CHAIRMAN. Thank you.
 Senator Bingaman.

STATEMENT OF SENATOR BINGAMAN

Senator BINGAMAN. Thank you very much.
 Madam Secretary, thank you for being here.

Let me ask about an issue that is a little bit off the subject of your direct testimony here, but it is a very important part of the bill that I would like to see us move ahead with; it relates to implementation of the workforce provisions that are contained in title V.

A central part of the reform, as I saw it, was creation of a new independent and nonpartisan national workforce commission; this is something which is not under your department directly; it's an independent commission. It's tasked with providing Congress and the Administration with clear information and guidance on how to align our Federal resources to meet the health care workforce needs of the Nation.

It's based on recommendations that the Council on Medicine Education made, and modeled after MEPAC, which, of course, provides us with expert guidance on Medicare payment issues; it had strong support, I believe, bipartisan support when we included it in the bill.

It's my understanding that the commission members were selected by GAO; Dr. Peter Buerhaus is the chair. The commission may provide a report as early as October 1, but the commission cannot begin its work until it gets funding to do its work.

The appropriations bill that came out of the Labor HHS Subcommittee and that we tried to pass on the Senate floor, included \$3 million for operation of the commission; it's unclear, now, what the funding status is.

I wanted to just flag this issue for you. I know, this is not your responsibility directly, but I think it is very important.

A very important part of health care reform, is dealing with the problem of how to channel Federal funds most effectively to meet our health care workforce needs.

I don't know if you are familiar with the issue. If you have any comments you'd like to make, I'd be glad to hear those.

Secretary SEBELIUS. Senator, I think that the issue of the health care workforce is an enormous issue.

Whether or not we had passed an Affordable Care Act, it's an issue that's been looming on the horizon, and frankly, ignored for decades. Where are the providers that we need for the future? What's the pipeline? How do we get there in an expedited fashion; and what's an accurate snapshot?

The Workforce Commission—I have seen the members' names and bios, and it's a stellar group and one that we look forward to working with.

The Health Care Act also expanded the National Health Service Corps, which allows, in exchange for scholarship and loan payment, providers to serve in underserved areas, which is a significant step forward; it increases—thanks to the Prevention and Wellness Fund, there was a \$250 million investment, and again, additional

primary care providers, which will train about 16,000 new providers over the course of the next 5 years.

We have, as part of the act, some nurse-led community health centers, increasing nurse practitioners and providers. But I think that the challenge of making sure that all Americans have access to health care providers, and particularly, primary care, gerontology, mental health providers; if we're shifting to a wellness system, we need the providers on the ground who are able to deliver that care.

That's certainly part of the effort that you all have begun with the Affordable Care Act, and accelerated what has been a longstanding challenge, but one that we are paying very careful attention to; and, the President has, as a high, personal priority, to make sure we have the workforce needed by the American public.

Senator BINGAMAN. Could I just ask that you maybe have someone on your staff look into the issue of how we can get the—

Secretary SEBELIUS. Yes, sir.

Senator BINGAMAN [continuing]. The funding for this commission to do its work? As I say, I think they're ready—up and ready to go. They obviously need some staff to assist them, and they need to pay that staff; so it's not a substantial amount of money, but I do think it's a very important task that we've given them.

If you could look into that, I'd sure appreciate it.

Thank you.

Secretary SEBELIUS. I'd be glad to.

The CHAIRMAN. Thank you, Senator.

Senator Bennet.

STATEMENT OF SENATOR BENNET

Senator BENNET. Thank you, Mr. Chairman, and I'd like to thank you and the Ranking Member for holding this hearing.

Madam Secretary, thanks for coming back.

If I had to sum up the last 2 years of my town hall meetings in Colorado on this issue, what I would say is that people are saying: We hated the system as it existed, the health insurance system, and we also believe deeply in your capacity—my capacity, not yours—to make it even worse than it is now. I think the rancor on the debate on health care didn't do much to create a level of confidence in all this.

One of the things that I talked about was that, when people said, "We don't believe government can do a good job here; look at what government has done before," I said, "You have a point."

At the heart of this reform, in many ways, is an attempt, a rare attempt to actually change the incentive structures so that we can deliver higher quality at a lower cost; something that we historically, have not done, but something we have to do, not just for the health of our citizens, but for the quality of the care that we've got and so that we don't bankrupt the United States of America.

One of the things I learned during the health care debate was that, because of the way the incentive structure worked, one out of every five Medicare beneficiaries that went to the hospital were readmitted within a month for conditions that were completely preventable.

Medicare, as a result was spending \$17 billion a year on these hospital re-admissions that could have been prevented.

It's one of the reasons why I work so hard on something called the Community Base Care Transitions Program. This innovative model ensures that each Medicare beneficiary, at risk of being re-admitted, is assigned a code to make sure that they go in and out of the hospital, nursing home, and even their own home, and that they do the follow-up care and take their medications.

This practice known as transitional care, has shown a reduction of up to 50 percent in places with high re-admission rates; and I'm very proud that this was homegrown in the State of Colorado based on work in Mesa County and Denver.

Madam Secretary, I just wanted to ask whether you're seeing this across the country. Are people starting to think about how we change the delivery model to create higher quality at a lower price; and what can we do to accelerate that work?

Secretary SEBELIUS. Senator, I think that's a great question. The earlier discussion really focused on some of the insurance market changes, but I think the underlying health costs and the amount that is spent on things that may not lend themselves to the health of anyone, are areas that providers and employers and others are eager to work on.

And, in the case of this coordinated care strategy, when someone leaves the hospital, we know it works; it's in pockets around the country, but never really taken to scale. It's better for patients; it's better for their families; it's better for their health, and certainly lowers costs of unnecessary re-admission.

So, having an opportunity to employ those best practices across the country, deploy those tactics, that bundled care, the medical home model, which we know is again very successful—the kind of early intervention.

A lot of those strategies are incorporated into the Affordable Care Act, and give direction to our agencies to implement those across the board; and I think that will be very good for the American public's health and for our health care costs.

Senator BENNET. I agree, and I will say I think it's been lost in the debate, which is why I raise it here today; and, the providers in my State that are working on these things, and in many ways have some of the most forward-leaning approaches to this, are really excited about the possibilities here.

And, that really brings me to my second point, which is that we've heard discussion on both sides today and throughout the debate about the CBO numbers; does this really save money; is it going to save money over time?

I think the honest answer to that question is, it depends on how well we execute. You know, it depends on how well you execute it. It depends on how well the States execute it, and it's one of the reasons why I worked with Senator Hagan and Senator Warner on a fail-safe amendment that would have said:

“Look, if we don't save the money that we are committed to save, that we have said we would save, that we will look at it again as a Congress and make sure we have those savings, because we want to keep faith to the American people who rea-

sonably are saying: 'We're not sure what to believe; we're not sure which side, you know, is right'."

And since it's a projection, we don't really know.

My own view is that if we put more of these transitional care models in, we may save even more money than we've talked about.

So, I wonder whether you'd be willing to work with me, and Senator Hagan, and Senator Warner, and other members of the committee, to see whether we might be able to write a piece of legislation that could give the American people confidence, that when we say we're going to save the money, we mean we're going to save the money?

Secretary SEBELIUS. I'd be delighted to do that.

Senator BENNET. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Bennet.

Senator Roberts.

STATEMENT OF SENATOR ROBERTS

Senator ROBERTS. It seems to me that you might want to ask Richard Foster to join that group, to save a lot of talking back and forth.

Madam Secretary, thank you for coming.

I should inform my colleagues that the Secretary and I go back quite a ways, from a family standpoint, and also from serving at the same time with the Distinguished Secretary when she was Governor of Kansas. I worked for her father-in-law when he was in the Congress, and worked with her husband, Gary, who is now a very prominent judge, when he was a rather rowdy student—

Secretary SEBELIUS. Just say he was younger.

[Laughter.]

Senator Roberts [continuing]. When he was younger at Kansas State University, home of the ever optimistic and fighting and losing wildcats.

Secretary SEBELIUS. I wore my purple for you.

Senator ROBERTS. Thank you.

[Laughter.]

I appreciate that. Thank you.

We have a mutual friend who has a preexisting condition that we all know about, and—Rudy Brodesco called and indicated that he would like to talk with you. He talked with me for about an hour, so I transferred him over to your office, so then you can—

Secretary SEBELIUS. Thank you.

Senator Roberts [continuing]. You can visit with him.

I understand that Dr. Berwick is back, that he has not parachuted in, that he is going to be recommended by the President, or has been recommended by the President to again be the Head of CMS; is that correct?

Secretary SEBELIUS. He's been re-nominated, yes, sir.

Senator ROBERTS. He's been re-nominated. Good, I hope that in the Finance Committee we can take enough time to really get at some of the challenges that we face.

Dr. Berwick has, unfortunately, been tagged with the title of The Chief Rationer, with all of the regulations that are pouring out of your department.

I understand a couple of weeks ago that some boxes were moved and he is now in charge of oversight of the regulations. Obviously, they would have to finally be approved by you, but historically, it was in the Secretary's Office; now it's under Dr. Berwick; is that correct?

Secretary SEBELIUS. The office of?

Senator ROBERTS. Of CMS.

Secretary SEBELIUS. Yes. Yes, sir.

Senator ROBERTS. So, that's a recent development. I don't know if that gives me pause or what.

But at any rate——

Secretary SEBELIUS. Senator, we did that to maximize, I think, efficiencies. It was going to be an independent office; and once we looked at overhead costs of duplicating everything, from front office help to legal staff, it was seen——

Senator ROBERTS. I got it.

Secretary SEBELIUS [continuing]. As an expedited way to maximize and leverage our assets.

Senator ROBERTS. Maximizing Dr. Berwick does give me pause. But at any rate, let's go on to another subject.

As former Governor of Kansas I know you are very well aware that we have 83 Critical Access Hospitals out in our State, the most of any State, fully two-thirds of our hospitals. You also know that the Critical Access Hospitals are not part of the 5-year exemption from the IPAB review—that's the what, Independent——

Secretary SEBELIUS. Payment Advisory Board.

Senator ROBERTS [continuing]. Payment Advisory Board, yes, very independent, to say the least.

I'm not happy with that. I think we abrogated our responsibility as individual members to set the Medicare reimbursement rates as best we know them, but that is a battle that we lost in the health care reform, and so we have IPAB.

But the Critical Access Hospitals, of which there are many in Wyoming, many in Iowa, many everywhere here, are not part of that 5-year exemption from the IPAB review.

Should the IPAB recommend reductions that take funds away from these rural community hospitals, I can assure you Congress will act. It's a rather Byzantine-kind of way to do it, but you got to get 60 votes. I'm sure the House would do it. Then if you did it, the President would veto it. Then you got to come back and override the veto with 67 votes. In the meantime, 83 Critical Access Hospitals—Abilene is a good example—Ellsworth—you know these folks and they know you.

So, my question is: Would you support such a recommendation to at least include the 83 Critical Access Hospitals?

I don't know why this happened, and Max Baucus doesn't either. Pardon me for interrupting you. But even on reconciliation I tried an amendment that would at least make them consistent with other hospitals.

That was during the time that, you know—all those in favor, say aye, aye; all those opposed, say no; and there was a resounding no. And that's the way it went.

So, you know, what do you think?

Secretary SEBELIUS. I share your belief that Critical Access Hospitals are incredibly important in States across the country; and I would just say that I'm committed to working with you to take a look at what the gap is, and what can be done about it, short-term.

I think it's important that those hospitals not be jeopardized, or the care they deliver be cut off from citizens around the country, including in Kansas.

Senator ROBERTS. Most of us were very pleased to hear about the President issuing an Executive order in applying the principles: That each agency is directed to use the best available techniques, to quantify anticipated present and future benefits and costs as accurately as possible.

But, as we later found out, each agency, as they put up the yardstick to figure out the cost-benefit ratio or situation with any regulation, there's more language; and it says—and this is the part that I have the most concern: Also to be considered are values that are difficult or impossible to quantify, including equity, human dignity, fairness and distributive impacts.

Are you anticipating you will be able to determine which regulations, including the ones recently released from the health care regulations that HHS would fall under this exemption? Are you exempt; are you not exempt; are the regulations your Department oversees exempt—where are we, here?

Secretary SEBELIUS. We certainly don't consider HHS exempt from the—directed by the President; and we've already launched a process to examine the whole host of regulations with the parameters that he outlined. So, no, we are definitely not exempt from that regulatory review.

The CHAIRMAN. Thank you, Senator.

Senator ROBERTS. I have a list that I'd like to share with her—not now, but I will send you a list. And I look forward to working with you.

Thank you.

Secretary SEBELIUS. Thank you, sir.

The CHAIRMAN. Thank you, Senator.

Senator Reed.

STATEMENT OF SENATOR REED

Senator REED. Thank you, Madam Secretary. Thank you, Mr. Chairman.

Recalling some of the discussions in the health care debate, one of the issues around the elimination of preexisting conditions exclusions in health insurance policies was the need to have, frankly, mandatory coverage; and that, I think, was an issue that was pushed very aggressively by the insurance industry.

Secretary SEBELIUS. That's correct.

Senator REED. In fact, their view, basically, was that if we provide this benefit, which could be, frankly, the most popular aspect of the health care reform, that is, if you have the resources, you can buy insurance, regardless of your health care condition.

It was, again, just to sort of put it in context, it was as much the insistence of the insurance industry than it is any sort of policy-making here in Washington, that mandatory coverage has to be part of it now.

Secretary SEBELIUS. I think, Senator, it was brought to the table by the insurance industry, by the Association of Health Insurance Plans, and others, to guard against an adversely-selected marketplace if only the sick are in an insurance pool that's immediately unaffordable.

Senator REED. So, looking at—sort of turning it around and at the logic of this is that, this provision, which people say, “Oh, we really like that”—I don't know if you've seen the polling data, but I would assume it's in the 1980s or 1990s percent; you've got to keep this—would, frankly, require that this universal approach to coverage through private markets has to be maintained also; is that your view?

Secretary SEBELIUS. To have viable, private market, you—

Senator REED. Right.

Secretary SEBELIUS [continuing]. You have to have a pool of sharing the risk, yes, sir.

Senator REED. There has been lots of discussion about what's popular. We'll keep what's popular, we'll eliminate what's unpopular. Popularity is in the eye of the beholder.

But in order to have a comprehensive system where everyone can receive coverage, can buy it through the private markets with assistance, if necessary, then you have to have, essentially, the framework that you've set up, the interchanges and the requirements to participate fully.

Secretary SEBELIUS. It's part of a market strategy that keeps a market solvent.

Senator REED. One of the issues that I thought Senator Enzi brought up is very important, is the issue of these child-only plans.

There are some States where there is either actual departure of companies with these policies or threatened departures; and I'm wondering if there's anything the States can do.

I know we passed significant reform, but you are a former insurance commissioner. Up until the passage of this act, most of the action of insurance health care and otherwise was at the State level.

The other aspect of this question would be: What about the 40 States where—some, I know, don't have these child-only policies, but have done things to ensure that children are protected?

Secretary SEBELIUS. Senator, you're absolutely right. Again, the Affordable Care Act doesn't change the fact that States have the leadership position in this framework; so whether it's setting up the insurance exchanges or the high-risk pool, or regulating their marketplace, it is a State-based strategy, and we're working closely with those State regulators.

Many States since the passage of the Affordable Care Act—and many of them before, had taken action to say that it will—if you want to sell insurance in our State, you must offer policies across the board.

A number of States have actually passed that legislation since the Affordable Care Act and the companies threatening to leave the marketplace feeling that that is a very discriminatory position for

insurance companies to take. So that is, indeed, being contemplated.

As I said earlier to Senator Enzi, there also are a number of companies who immediately said that they would likely not stay in the market, who have reconsidered that position, and, indeed, are very much in the market.

Senator REED. Madam Secretary, again, thank you. I think you've been given one of the most challenging assignments in Washington, and you have been working tirelessly to get it done, and I appreciate very, very much what you and your colleagues have been doing. And I anticipate that the challenges will continue to appear along the road.

But, thank you, so much.

Secretary SEBELIUS. Thank you.

The CHAIRMAN. Thank you, Senator Reed.

Senator Burr.

STATEMENT OF SENATOR BURR

Senator BURR. Welcome, Secretary.

Secretary SEBELIUS. Thank you, Senator.

Senator BURR. Madam Secretary, if I heard you correctly, when Senator Enzi asked you a question about CMS's projections, and specifically, they were that this would bend the cost curve of \$251 billion, and that the national health spending would increase \$311 billion, and I heard you say, I think, that you disagreed with the analysis that came out of CMS.

Secretary SEBELIUS. Again, Richard Foster—

Senator BURR. Richard Foster.

Secretary SEBELIUS. Yes, is an independent actuary.

Senator BURR. Let me ask you, what's the Administration's position on fixing the SGR?

Secretary SEBELIUS. The President has said, since elected he would like to see a permanent fix of the SGR.

Senator BURR. You used, to make your case to Senator Enzi, CBO. Now, CBO says in their estimates they failed to take into account \$250 billion that would be necessary to fix SGR.

So, if the President's commitment is to fix SGR, then, in fact, that eats up all the savings you've talked about; is that correct? All the savings that come from health care reform will be eaten up by the addition of a fixed SGR—just by your numbers.

Secretary SEBELIUS. It would cost \$200, yes; I don't know what the cost is, but—

Senator BURR. OK. The Health Care Reform bill creates a new tax on medical devices. Would you be supportive of repealing that tax?

Secretary SEBELIUS. No, sir.

Senator BURR. Let me ask you: Does that not fly in the face of what the President said Tuesday night to Congress, and to the country, where he talked about winning the future, and out-innovating the rest of the world; does that not make us uncompetitive and force innovation out of the country by taxing innovation?

Secretary SEBELIUS. I think that there are taxes on a lot of innovative products that actually don't deter the innovation from moving forward.

I don't necessarily think that you have to remove all tax payments. As you know——

Senator BURR. No, I'm talking about——

Secretary SEBELIUS [continuing]. The medical device, equipment, initially the Congress looked at a significantly higher tax, and in the course of discussion and input, they decided to significantly lower that tax and to not impede progress.

Senator BURR. But this is a new tax on medical devices that are being used by patients, which is one of the contributing reasons that the Chief Actuary says, health care cost is going to go up, because we've begun to increase the cost, not just of the delivery, if we fix SGR, but the actual cost of the products that are in the health care system.

So, let me ask you: NIH has just talked about a new program where NIH is going to get involved, in some degree, in drug development; is that something you're supportive of?

Secretary SEBELIUS. Senator, they have been involved in accelerating drug development.

Senator BURR. They've been involved in research, of promising compounds and——

Secretary SEBELIUS. That's true.

Senator BURR [continuing]. Directions. But, I sense a distinct difference between that and drug development, which is something that the private sector, or academia has been engaged in almost 100 percent.

Secretary SEBELIUS. Senator, I know that you come from a State, as does Senator Hagan, who has a lot of knowledge and expertise in drug development. I think what Dr. Collins has identified is that there are still way too many promising ideas that die somewhere on the vine between the microscope and the marketplace, and is trying to mobilize Sherpa teams, activities, any incentives that can make sure that we can actually get the patients those breakthrough drug developments; and too many of them never make it to the market.

Senator BURR. Clearly, I think that will have a cost involved in it, but it will also have a cost on the private sector's inability to chase those promising things if we choose to do it as a government.

Madam Secretary, I think we can all agree that there are many things, that if we sat down today, we could tick off in this bill that we could all support.

We could eliminate preexisting conditions. We could make sure that every State had a risk pool. We could agree that children should stay on their parent's health care plan until age 26.

Now, I lived it. I'm a Federal employee. I'm a participant in the largest employer in the country. My kids were kicked off of my insurance at 22.

I guess I would ask you, for those members that were here until this plan was passed, that are critical of the private sector having their insurance that limited children's inclusion to 22 or 23 or 24, but not 26, are they hypocritical in questioning that, when they had the opportunity to change the OPM guidelines and change the largest employer in the country to age 26 before this massive health care reform plan was passed?

Secretary SEBELIUS. Senator, I don't think it was hypercritical. I think it's an unfortunate oversight, and we found that the contracts precluded us from changing as rapidly as some of the private market plans could change; but that change will be made, and Federal employees across the country, including Members of Congress, can look forward to keeping their children on their plan.

Senator BURR. In conclusion, Mr. Chairman, we have over a thousand employers who have applied for a waiver. Fifty-seven hundred-plus have been approved; 50-plus have been denied. In addition to that, CMS estimates that in the grandfather regulation, it's estimated, your own estimates, 80 percent of small business could lose their grandfather status.

I'm not sure what happened to, if you like it you get to keep it. But you said, "Americans will have more control over their health care."

My conclusion, after reading the plan numerous times, what we've done is, the Federal Government has more control over health care, not the American people.

I thank the Chair.

The CHAIRMAN. I thank the Senator.

Senator Isakson is gone.

Senator Sanders.

STATEMENT OF SENATOR SANDERS

Senator SANDERS. Thank you very much, Mr. Chairman.

Madam Secretary, thank you for being here; thank you for the excellent work that you've been doing under very difficult circumstances.

Just two lines of thought that I want to pursue: In the Health Care Reform bill, some of us, including Senator Harkin and many other people on this committee, worked very hard to expand community health centers, because we believed that one of the great crises in this country, and one of the reasons that 45,000 Americans die every single year, is they don't have access to health care; and, in fact, some of those people even have health insurance.

So, we saw a crisis in primary health care. As a result of this legislation, we doubled the number of community health centers, opening up an opportunity for 20 million more Americans to get good quality health care, dental care, mental health counseling and low-cost prescription drugs.

Can you give us, maybe an update as to how progress is coming along in terms of the community health center program?

Secretary SEBELIUS. Certainly, Senator, and again, I applaud your leadership on this issue. It's an incredibly important framework for health care improvements across the country; and I try to visit health centers every trip I make, and they are impressive neighborhood community organizations, delivering high-quality, lower cost care to millions of Americans.

We are working very quickly to implement the strategy that's laid out over the next 5 years. The first step was to put money in the pipeline for important improvements and additional services, additional dental care and mental health care.

We're putting out the new access point, grant proposals that will be released this year and over the next several years. Also an im-

portant feature of the community planning proposals is going out the door in 2011; so those communities which haven't quite gotten the wherewithal to actually make the full-blown proposal will have an opportunity to bring together providers and community groups.

But, certainly that footprint of community health centers expanding across the country, and new sites; so it will be both new access sites and mobile sites connected to existing health centers, whether that be in schools or vans or other—

Senator SANDERS. I should tell you, Madam Secretary, that in Vermont we're making real, real success; and if you're really nice to us in the next couple of years, and you grant a few more requests, every part of the State of Vermont, every county, every area in the State of Vermont will enable its people to have access to community health centers, which we think is a real step forward.

Would you be in agreement with a study, coming out of George Washington University, which says that the investment that we made, in fact, is going to save substantially more money than we spend, because we're going to keep people out of emergency rooms; we're going to let them get to a doctor when they should; not get very sick and end up in a hospital at great cost.

Secretary SEBELIUS. I haven't seen the study, but I certainly have seen that practice in place. In fact, some of the most creative and, I think, beneficial work going on around the country is health care—community health centers working in collaboration, with community hospitals—

Senator SANDERS. Right.

Secretary SEBELIUS [continuing]. Appropriately, sort of reassigning folks to care—

Senator SANDERS. Other than utilizing—

Secretary SEBELIUS [continuing]. That is preventive care.

Senator SANDERS [continuing]. An emergency room.

Secretary SEBELIUS. You bet, you bet.

Senator SANDERS. All right, let me switch gear, and pick up on a point that Senator McCain made a moment ago; and I'm sorry he's not here. As you may know, the State of Vermont is giving serious thought to moving forward toward a Medicare-for-all-single-payer program. Our approach and our request for a waiver may be a little bit different than Arizona's. We do not want to throw people off of health insurance; we want to make sure that every person in our State is covered.

We believe that that approach—and there was a study that just came out by Dr. Hsiao, who you may know is an economist at Harvard, who developed the health care program in Taiwan.

We believe that we can save many, many hundreds of millions of dollars through a Medicare-for-all-single-payer program. I know that we have to work on that waiver legislatively; that's not something that you can give us on your own.

But, would you be prepared to work with us, as we walk down that road, saying that in a federalist nation—we have 50 different States—that maybe the Nation can learn from what Vermont or other States are doing with increased flexibility?

Secretary SEBELIUS. Senator, I was appreciative of the meeting that you attended with your newly elected governor, and applaud the work that Vermont has done.

States across the country often have been well ahead of the Federal Government in terms of creative health strategies, to expand coverage to citizens, and we very much encourage the kind of flexibility, the State-based approaches which this bill is built around; and I look forward to working with you.

Senator SANDERS. All right. Our goal there is to maintain the high standards of the national legislation, but to give States flexibility to show how, in their particular areas, they may be able to do it better at a more cost-effective way; so we'd appreciate working with you.

Secretary SEBELIUS. Sure.

Senator SANDERS. With that, Mr. Chairman, I thank you, very much.

The CHAIRMAN. Thanks, Senator.

Senator Hagan.

STATEMENT OF SENATOR HAGAN

Senator HAGAN. Thank you, Mr. Chairman.

Madam Secretary, I, too, want to thank you for all the hard work you've put in to date, and for being here today.

But I also am pleased with the partnership that the Department of Health and Human Services is forming in North Carolina, especially with our State insurance commissioner, as they are moving forward to establishing the exchange.

I also wanted to talk for just a minute about having the young adults on the parent's policies until they're age 26.

The State of North Carolina actually has done that for years for State employees, if the students were still in school. I know that when I switched and became a Federal employee that my children had to find health insurance.

I have one son and one daughter; and it was incredibly more expensive for the young woman to buy health insurance than it was for the man.

So, I'm very pleased that when you think of two young people going out into the workforce, getting the same pay, the young woman was drastically affected, in a different way, month to month, because of her higher increase in just purchasing health insurance. So, I'm pleased that that has been changed.

In your testimony you mentioned that the new benefit impacting hundreds of thousands of families from across the country, allowing these young children to remain on their parent's insurance until age 26; and we do have about 37,000 of them that continue to be insured under their parent's health plans.

I know that in the next panel we'll be hearing about the impact of this new benefit; but, I understand that it is so popular that Congress extended that benefit to military families last year.

And, with that, I'm wondering if you could elaborate on the impact of this benefit; and how many adult children do you know that might be participating across the country; and could you provide some thoughts on what would happen if this benefit happened to be repealed?

Secretary SEBELIUS. Senator, I think the situation you describe in North Carolina was in place in, again, a number of States, but often was tied to school, full-time school.

So if kids aged out of their policy at 22 and were not in school, they, again, lost their coverage. So this is impacting lots of families at lots of different ages, in a very beneficial way; and, again, I think, is a great illustration of putting back together a larger pool of folks and bringing them back into the marketplace, because the number of young Americans was the second-highest category of uninsured Americans.

The highest was those 55 to 64 who often were really priced out of the market; but young Americans were the second-highest category of uninsured in this country. So, this family strategy, I think, goes a long way.

I can't give you exact numbers today. We'd be happy to try and collect those for you—but, I think clearly, this is impacting millions of young adults around the country in a very positive way, and allows those young adults to think about being an entrepreneur, or start their own business, or strategies that, again, were impeding their ability to really launch into a professional career if it did not come attached with health insurance.

And, like you, Senator, I had two 20-somethings who lost their coverage once they got out of school. We were lucky, because both my boys were healthy, but they had friends who were not so lucky and not so healthy, who had a terrible time finding and purchasing health insurance.

Senator HAGAN. On a whole, young adults are typically very healthy individuals. So, really, that's helped from an actuarial standpoint to have more of those on policies.

But also in your testimony, you mentioned the preexisting condition insurance plans. The Inclusive Health is running the North Carolina plan, and has currently right now, over about 800 participants to date, which I understand is one of the highest in the country; however, I know that one of their challenges has been raising the awareness and getting those who are uninsured enrolled.

My question is: Could you talk about some of the challenges that States are having in getting people enrolled, and some of the other efforts that they are making to raise awareness among the uninsured population; and does HHS offer guidance to States on ways to increase this awareness?

Secretary SEBELIUS. Great question, Senator. I think one of the challenges is, as you say, that a lot of people weren't aware that these even existed; so we are certainly trying to help amplify that message, that in every State in the country there is now a new option for adults who still are locked out of the market with a pre-existing health condition and we'll continue to do that.

We've also done a lot, in conjunction with States, of outreach to disease groups, to faith-based communities, to community leaders, to again, make them aware that these are new.

In many States the benefits just became available late this fall, so we're talking about the early couple of startup months, but, we don't miss an opportunity to remind people that this is one of the benefits of the new Affordable Care Act that did not exist before, and actually, because the rates are pegged to market rates, can be a much more affordable option for those who have been uninsured for the last 6 months.

Senator HAGAN. I will say, in North Carolina we had put that in place earlier, although it is still like a pretty expensive policy.
 Secretary SEBELIUS. Right, right.
 Senator HAGAN. Thank you, Madam Secretary.
 Secretary SEBELIUS. Yes.
 The CHAIRMAN. Thank you, Senator.
 Senator Murray.

STATEMENT OF SENATOR MURRAY

Senator MURRAY. Thank you, very much, Mr. Chairman for having this hearing.

Madam Secretary, thank you for the tremendous job you and all the folks at HHS are doing, implementing this law and helping families get access, as we had envisioned.

I know you have another panel, so I'm just going to ask one question and go back to your testimony.

You talked about the new resources that the Affordable Care Act is now providing to States to help prevent unreasonable premium increases, and you mentioned that grants have already started going out to our States to help strengthen their ability to review and reject unreasonable rate hikes.

Can you talk a little bit about how this will make the process of premium increases more transparent for all health care consumers?

Secretary SEBELIUS. Certainly, Senator. This is another area where the bill that you all helped to put in place contemplates that States are the leaders in the health insurance market, and States are the regulators of their own health insurance market, but also recognizes that often those resources are not adequate to do a robust job of rate review; particularly in tough budget times a lot of States have cut back.

So, there are additional resources available and taken advantage of, I think, by virtually every State in the country to increase and enhance the oversight provided by those State regulators.

What we are doing right now with healthcare.gov is publicizing rates. For the first time, consumers can go on a Web site and get an overview of what rates are being charged by what plans in their particular jurisdiction; but two other important pieces of information: How many people are denied at that rate, what percentage are not offered a policy at that rate, and how many times the rate deviates from that. So, that, again, is available and updated on a regular basis.

Insurance commissioners are also committed to now, on Web sites, and their plans making the rate-review process far more transparent; asking for underlying actuarial information from companies, holding hearings, having available to the public what has often been a very opaque, very misunderstood system—much more transparency, much more openness, much more oversight.

And, the combination of consumers being able to pick and choose, finally, line up plans side by side and choose what's best for them, and a much more rigorous review, has already yielded results where excessive rates have been turned down and new rates have been submitted that are far less impactful on the consumers with those policies.

Senator MURRAY. I applaud you on that, because we always hear about how competition is what drives the cost down. Without transparency, it's pretty hard to know how you can impact healthcare costs. But, I think this open, transparent way that people can now view insurance policies is what we envisioned helping to bring those costs down.

So, I really appreciate your work on that.

Secretary SEBELIUS. One could argue that you could get more information on the toaster you bought than the health insurance plan for yourselves and your families; and we're trying to work very closely with our partners at the State level and give a very transparent, very open system.

Just lining the prices up side by side really does begin to change strategies of companies. They don't want to be the top price in the marketplace. So, that, in and of itself, has been very helpful.

Senator MURRAY. Great. Thank you, very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Madam Secretary, thank you very much for your appearance here, and for your answering questions in great order.

As I said we'll leave the record open for 10 days; some Senators may want to submit some questions in writing.

But, again, I want to personally also thank you for your great leadership in all areas of health care and human services, but especially in the area of implementation of the Affordable Care Act.

Secretary SEBELIUS. Thank you, Mr. Chairman. I look forward to working with you and the committee.

The CHAIRMAN. Thank you, Madam Secretary.

Next, we'll call our second panel.

I thank this panel for being here; I know that some of you came a great distance, and I appreciate your patience in sitting through the testimony; I hope that it was informative for you as it was for us up here.

On our second panel, from left to right we have Ms. Lisa Grasshoff; she works for the Paragon Hemophilia Solutions in Houston, TX, a home-health company focusing on those with bleeding disorders. Ms. Grasshoff's experience with bleeding disorders is personal, as her son, Joshua, suffers from two of these diseases, Hemophilia-A and Type III von Willebrand Disease. She's accompanied today by another member of the bleeding disorder community, Ms. Tammy Davenport; is that correct?

Thank you for being here and for sharing your stories.

Emily Schlichting, a junior at the University of Nebraska, our neighbor to the west, majoring in political science and communications. Ms. Schlichting suffers from a chronic autoimmune disease called Behcet's Syndrome. She knows firsthand the anxiety of obtaining health insurance while suffering from a dangerous disease.

We thank you for being here, and we look forward to hearing your story.

I will yield to Senator Reed for the purpose of introducing Commissioner Koller.

Senator REED. Thank you very much, Mr. Chairman. I'm just delighted to be able to welcome Chris Koller to the panel. He is offi-

cially, the first Health Insurance Commissioner for the State of Rhode Island.

He was appointed by a Republican governor; reappointed by an independent governor, and unusually supported by the Democratic Delegation of Rhode Island. So, he's managed to bring everybody to the table.

Before Chris became the first Health Care Insurance Commissioner, he was instrumental in setting up the Neighborhood Health Plan of Rhode Island, which is a safety net insurance plan, which not only is effective in providing care, but it's also recognized as providing excellent care; it's the bulwark of our Medicaid Program in the State of Rhode Island. So, he comes to this task with extraordinary skill.

He's a graduate of Dartmouth College, and holds a Master's Degree in Management and Religion from Yale University, and in a given day, he needs both theology and management to get things done.

I just say personally, I've had the privilege of knowing Chris, and being a friend. There's no one with more intelligence, integrity and dedication—and selfless dedication than Chris Koller. So I'm just honored that I could introduce him, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Reed. I'm also aware of the travails that you went through to get here. I was following your travels yesterday, and my staff kept advising me, because of the weather, you were unable to take your flight; and as I understand, it took you 10 hours on the train to get here; so we really appreciate your diligence and effort to be here.

Last, we have Mr. Olivo?

Mr. OLIVO. Olivo.

The CHAIRMAN. Our final witness is Mr. Joe Olivo. Mr. Olivo is the president and co-owner of a burgeoning printing business, Perfect Printing.

Mr. Olivo co-owns the company along with his wife, mother and two brothers in New Jersey. He has grown his business from 10 employees to 45 employees.

Boy, I wish we could do that all over the country.

Thank you very much for coming, Mr. Olivo.

So, again, as you know, we'll take all your testimonies as they are written in order, and they will be submitted to the record in their entirety.

I'd just like to ask, as we go through, if each of you will just sum up in a few minutes—I don't have a distinct cutoff time, but, 5 minutes or so, what it is that you want us to know.

I know I always say this to, a lot of times to witnesses who have come a long distance and all of a sudden, Senators have disappeared. I assure you that their staffs are here. I can assure you of that. And, I can say this, there's an old saying around here that Senators are a constitutional impediment to the smooth functioning of staff.

[Laughter.]

So, our staffs do a lot of the work, so I want to assure you that your testimony and your being here is being well-noted and supported.

We'll start with Ms. Grasshoff. Welcome, and, please proceed.

STATEMENT OF LISA GRASSHOFF, HOUSTON, TX

Ms. GRASSHOFF. Thank you. Good afternoon, Mr. Chairman, Senator Enzi and fellow Senate committee members.

Thank you for inviting me to share my story about the positive impact the Affordable Care Act has had on my family. It is both an honor and a privilege to have the opportunity to address this committee and have my voice heard.

Again, my name is Lisa Grasshoff and I live in Houston, TX, with my husband, Danny and our 20-year-old son. Danny and I have been married for 36 years and after 17 years of marriage, we were blessed with the birth of our only child, Joshua. Surrounded by many family and friends, Joshua was born 5 weeks pre-mature, and immediately I noticed that my baby was bruised above his eye and had numerous bruises on his body, which didn't make any sense because he was born by C-Section.

After extensive testing, Joshua was diagnosed with moderate Hemophilia A, or Factor VIII deficiency, which is an inherited genetic blood-clotting disorder.

Just to tell you a little bit about Joshua: He's an only child and the only grandchild on both sides of our family; and he's not spoiled, of course.

So, you know, obviously he became the focus of our world; and, therefore Hemophilia bleeding disorders was often a topic of conversation. We began trying to put the pieces together to figure out how and why did this happen, because we had no family history that we were aware of.

Thus, began my journey—my 20-year journey into the bleeding disorders community, which is where it all began.

Hemophilia is a very rare and chronic bleeding disorder that affects about 20,000 people in the United States, most of which are male. People with bleeding disorders require life-long treatment with high-cost clotting factor therapies, which replace the missing or deficient blood protein that allows our blood to clot.

Proper treatment, which must be administered intravenously, can prevent debilitating injury and life-threatening internal bleeding episodes. A lot of these episodes can occur spontaneously without trauma.

Factor replacement therapy is very expensive, in excess of \$300,000 annually just to sustain the normal clotting process that most people take for granted; and that is without any hospitalization or any trauma-induced injury whatsoever. And \$300,000 a year is unbelievable.

Our community population is relatively small, and therefore, there's a limited number of pharmaceutical companies that produce factor. Our costs will never decrease for factor; and we pay for it per unit. Our cost will only increase.

Currently, an infusion for my son, Joshua, runs about \$8,000 to the insurance company. That's a lot of money. There's not even a remote possibility that a generic medication will ever become available, like becomes available for so many other meds.

In order for everyone to truly understand why I'm here today, it's important that you really understand my family's story for the last 20 years, and how important the Affordable Care Act is for my family, as well as the bleeding disorders community in general.

In March 1994, at the age of three, Joshua suffered a life-threatening abdominal bleed. It came on again, spontaneously. He had 17 bleeding ulcers in his stomach for no reason. The doctors at the Houston Medical Center had never seen that before.

He required a 7-week hospital stay, two surgeries, numerous blood infusion, blood transfusions, massive doses of factor replacement, to stop the bleeding. During that time he literally coded three times; and by, coded, I mean he died and they had to bring him back to life. That was one of the worst times of my family and friends' life. It was very, very frightening.

Aside from that, our hospital bill was in excess of \$800,000. And I had a \$1 million policy. However, the medication expense didn't stop when we left the hospital. Because they could not explain why he had the abdominal bleed, we had to continue treating him prophylactically to hopefully prevent future bleeds. Therefore, he had to receive factor replacement on a daily basis for the next 4 years, every day of his life, and, every other day until he was 10 years old.

Currently, today Joshua treats prophylactically three times a week. So, again, we still have the costs. And this, again, was in 1994.

Unfortunately, Joshua continued to bleed spontaneously, whether it was his mouth or whatever, and we couldn't seem to get the bleeding under control, so we underwent further family genetic testing in 1995, and that's when he received a second diagnosis of Type III von Willebrand Disease, which, again, he is missing the complete von Willebrand protein.

The von Willebrand protein works in conjunction with the factor VIII protein to form a clot. Joshua has no von Willebrand protein and 4 percent factor VIII protein, which is considered moderate Hemophilia. And, they have to work together; and without having one factor, the other one doesn't work.

But, also at the same time, my husband and I received the diagnosis of mild von Willebrand Disease. We had no idea that we had von Willebrand Disease. It was quite a shock—quite a shock, because we had never had any symptoms of having that disease.

When Joshua was 16 he had a spontaneous head bleed the day before Thanksgiving. It's another day in my life that I'll never forget. It started with a really bad headache that we thought were migraines, because he also suffered from migraine headaches.

Long story short, I took him to the ER almost immediately, and they did a CT Scan, and he was having a brain hemorrhage. He was air lifted to the medical center, because I had taken him to an outlying Houston hospital; and from that point forward his life has changed.

Since that time he has had three more brain hemorrhages, and the reason he continues to take factor three times a week currently is to prevent the head bleeds, hopefully prevent the head bleeds; and fortunately, we have done that.

Now, that affected his life in school, because he missed so much school.

The treatment for von Willebrand Disease is different than Hemophilia. It requires a different type of factor; and by the time that Josh was 7 years old in 1998, we had maxed out three insurance

policies that had a million dollar cap, because the medication is so very expensive.

But to sustain our son's life, what do you—you know, that's a no-brainer. You do what you have to do.

And, during that period, when I maxed out my policy, fortunately, at that time in 1991 you could afford to have two health insurance policies because the premiums were so low; so therefore, Joshua switched over to his father's policy. We maxed that policy out.

My husband had to change jobs because of the insurance; took a lower-paying job. We maxed out that policy. Again, he had to take a lower-paying job, as I did as well.

And, you know, we work for health insurance, that's what we work for. And because my husband has had to change jobs so often, and we know how that looks on a resume, and the fact that he's 57 years old, and he is currently unemployed—he was laid off in June 2009. He is working a couple of part-time jobs now, but he has not been able to find full-time employment; and, you know, it's hard.

The preexisting condition, the elimination of the preexisting condition is totally awesome for us. I mean, it will make a world of difference.

The Affordable Care Act prohibits insurance companies from limiting how much they will pay for Joshua's lifetime, and will phase out annual caps over the next few years. And the fact that he can stay on our plan until he is 26 is phenomenal. That should give him enough time to become financially independent and get his college education, and find his passion in life.

But, more importantly, my husband and I now have peace of mind knowing that Joshua will continue to have coverage because of his bleeding disorder. Having access to affordable health care and quality medical care, will help him lead a full and active life.

His future is much brighter today than before the enactment of the Affordable Care Act; and for that I am very grateful. He now has the opportunity to reach his economical potential without health insurance rules dictating his choice of profession. His hopes and dreams are now without restriction.

Thank you very much for inviting me and listening to my story.
[The prepared statement of Ms. Grasshoff follows:]

PREPARED STATEMENT OF LISA GRASSHOFF

SUMMARY

My name is Lisa Grasshoff and my husband and I have a wonderful son, Joshua, who has moderate Hemophilia A, or Factor VIII deficiency, an inherited genetic blood clotting disorder.

After Joshua was diagnosed with Hemophilia A as a baby, I began learning everything I could about blood disorders and how to treat Joshua's particular condition. Joshua's disorder requires life-long treatment with high-cost clotting factor therapies. Factor replacement therapy is very expensive; in excess of \$300,000 annually. Plus, there are a limited number of pharmaceutical companies producing factor, so we are not able to purchase a generic drug.

When Joshua was 3, he suffered a life-threatening abdominal bleed that required a 7-week hospital stay, complete with numerous surgeries, blood transfusions and factor therapies. Our hospital bill was in excess of \$800,000. But the expenses did not stop there, as Joshua still needs treatments several times a week.

Not long after, Joshua was diagnosed with type III von Willebrand disease, which means he is also deficient in the von Willebrand protein needed to form a clot. This

disease requires additional treatments. Both of Joshua's conditions forced him to max out on three insurance policies, each with a \$1,000,000 lifetime cap, at age 7. My husband, Danny, had no choice but to change jobs, reducing our income by 40 percent, just to obtain health insurance for our family. Since Danny was laid off due to budget cuts, we now receive our insurance through my employer.

Thanks to the *Affordable Care Act*, our insurance company is prohibited from limiting how much care they will pay for during Joshua's lifetime, and annual caps are phased out over the next few years. The new law also allows Joshua to stay on our plan until he is old enough to become financially independent. More importantly, though, Danny and I now have peace of mind knowing that Joshua will not be denied coverage because of his bleeding disorder. Having access to affordable insurance coverage, and quality medical care will help him lead a full and active life. The future for Joshua is much brighter today thanks to the enactment of the *Affordable Care Act*, and for that I am very grateful.

Good afternoon, Mr. Chairman and fellow Senate Committee members.

Thank you for inviting me to share my story about the positive impact the Affordable Care Act has had on my family. It is both an honor and a privilege to have the opportunity to address this committee and have my voice heard.

My name is Lisa Grasshoff and I live in Houston, TX with my husband, Danny, and our 20-year-old son. Danny and I have been married for 36 years and after 17 years of marriage, we were blessed with the birth of our only child, Joshua. Surrounded by family and friends, Joshua was born 5 weeks pre-mature. Immediately, I noticed that my baby was bruised above his eye and had several other bruises on his body, which did not make sense because he was delivered by C-section. After extensive testing, Joshua was diagnosed with moderate Hemophilia A, or Factor VIII deficiency, which is an inherited genetic blood clotting disorder.

Joshua is an only child and the only grandchild on both sides of our family. So of course, he became the focus for all of us and Hemophilia was often discussed. We began trying to put the pieces of the puzzle together; we just wanted answers . . . why and how did this happen? Many other questions came to mind and thus, began my 20-year journey in the bleeding disorders community.

Hemophilia is a rare and chronic bleeding disorder affecting about 20,000 people in the United States, most of who are male. People with bleeding disorders require life-long treatment with high-cost clotting factor therapies, which replace the missing or deficient blood proteins that allow blood to clot. Proper treatment, which must be administered intravenously, can prevent debilitating injury and life-threatening internal bleeding episodes.

Factor replacement therapy is very expensive; in excess of \$300,000 annually just to sustain the normal clotting process that most people take for granted. Our community population is small; therefore, there are a limited number of pharmaceutical companies producing factor. Our costs will never decrease, only increase. A generic medication is not even a remote possibility for factor, as it is for many other drugs.

In March 1994, at the age of 3, Joshua suffered a life-threatening abdominal bleed that required a 7-week hospital stay. He required two surgeries, numerous blood transfusions, and massive doses of factor replacement to stop the bleeding in his stomach. His hospital bill was in excess of \$800,000. However, the medication expense did not stop there . . . he required factor replacement daily for the next 4 years and every other day until he was 10 years old. Today Joshua treats three times a week to prevent bleeds.

Upon further family genetic testing in 1995, Joshua received a second diagnosis—type III von Willebrand disease which means he is not only deficient in factor VIII, but he does not have the von Willebrand protein needed to form a clot. Both blood proteins must work together in order for the clotting process to be complete. Danny and I received the diagnosis of mild von Willebrand disease at this time as well.

Treatment for von Willebrand disease requires a different type of factor than hemophilia. Our choices are very limited, factor replacement is more expensive, and this placed more pressure on our need for the elimination of annual and lifetime caps. By 1998, Joshua maxed out three insurance policies with each having a \$1,000,000 lifetime cap. In order to obtain health insurance coverage for our family, Danny had no choice, but to change jobs making less money; therefore, reducing our income by 40 percent, yet our bills remained the same. On that same note, due to budget cuts at his company, he was laid off in June 2009, and to date is still not employed full-time. However, I have health insurance through my employer and we do not have to worry about maxing out another policy nor will we have to be concerned about a preexisting clause when Danny does find full-time employment.

The *Affordable Care Act* prohibits insurance companies from limiting how much they will pay for during Joshua's lifetime, and will phase out annual caps over the next few years. The new law also allows Joshua to stay on our plan until he is 26 and old enough to become financially independent. More importantly, though, Danny and I now have peace of mind knowing that Joshua will not be denied coverage because of his bleeding disorder. Having access to affordable insurance coverage, and quality medical care, will help him lead a full and active life.

The future for Joshua is much brighter today than before the enactment of the *Affordable Care Act* and for that I am very grateful. He has the opportunity to reach his economic potential without health insurance rules dictating his choice of profession. His hopes and dreams are now without restriction.

Thank you for your time. I will be happy to answer any questions.

The CHAIRMAN. Thank you very much, Ms. Grasshoff, for coming this great distance, and for sharing your story. I think it's a very poignant one, and right to the point of what we're talking about.

Ms. GRASSHOFF. Thank you.

The CHAIRMAN. Ms. Schlichting, my neighbor from the West, welcome, and please tell us your story.

STATEMENT OF EMILY SCHLICHTING, OMAHA, NE

Ms. SCHLICHTING. Good morning, everyone.

My name is Emily Schlichting. I'm 21 years old and I live in Lincoln, NE, and I'm a junior at the University of Nebraska. I'm here today because my life has drastically changed for the better thanks to the *Affordable Care Act*. I'd like to share with you just how that reform has affected my life.

I'll start, I guess, at the beginning, so that would be a good place.

The summer before my senior year of high school, when I was 17, I began experiencing a lot of really odd symptoms, which my doctors couldn't pinpoint.

My symptoms started as open ulcers that would get painfully and dangerously infected. It intensified in the next coming years to include high-grade fevers, swollen joints. I'd get these large, calcified lumps on my legs called Erythema nodosum, which hurt a lot; and just a lot of other symptoms that never really fit together.

After about 2 years of visiting multiple specialists, receiving MRIs and CT Scans, topped off by a week-long stay in the hospital my freshman year of college, I was finally diagnosed with Behcet's Syndrome, which is a rare autoimmune condition. It's similar to vasculitis.

As you can imagine, that's kind of a lot to have dropped on your head, having barely moved out of your parent's house at the age of 18.

But, despite going through all of that, I consider myself extremely lucky because my parents have amazing health insurance. And my condition, because of that insurance, was completely covered when I got sick.

I think something that really needs to be stressed here is that being sick is hard enough in and of itself. You know, like I was 18 years old, and all of a sudden I had swollen joints like an 80-year-old man. I was taking medicine that made $\frac{2}{3}$ of my hair fall out, and I couldn't go out on the weekends, because it hurt to get out of bed and walk to, like a party or over to a friend's house.

So I didn't have to worry about where my care was coming from while I was dealing with all that other stuff because of my parent's insurance.

However, when I did start to get my body under control, it became very clear to me that just because I had good health care under my parent's plan, didn't mean that I wasn't going to need to worry about where my care was coming from because I was soon to be off that plan.

When you're chronically ill, young, and your health care is tied directly to your employment, your job prospects become a lot more limited than you might imagine. Suddenly, taking a few years off to work at a nonprofit before I go to graduate or law school was no longer an option because a lot of those jobs don't offer great comprehensive insurance plans.

Beyond that, I could never drop off of an insurance plan because if I did, given the condition that I've been diagnosed with, it would have been almost impossible for me to get back on a plan.

Paying for my own health care would pretty much bankrupt me. I see, regularly, two rheumatologists, an ophthalmologist, a dermatologist, an internist and a couple other specialists for my condition because it's very rare and there's no one doctor that specializes in it.

Add to that medicine and preventive tests that I have to get all the time, whether it's a blood test for the kidney transplant medicine that I take every morning or just general checkups, it's really expensive.

And that's when things are going well.

So, the passage of the Affordable Care Act has made all of those issues go away for me. The dependent coverage clause has been a—it's a godsend. I mean, I can stay on my mother's insurance until I'm 26, which, hopefully I won't have to, and I'll be on my own feet and providing myself with insurance. But having that security, I mean, I don't think there are words to describe how important that is.

But, it gives me buffer time to figure out what career I want to pursue, and to work for a couple years to gain experience in that field before I go back to graduate or law school. Having the time to gain that experience is invaluable to me.

One of the things that struck me the most is how unfair it felt that I was being pushed into grad school to stay on an insurance plan, or, you know, forced to pay a really high COBRA fee, or forced to go uncovered and then not ever have insurance because of something that I couldn't control happening to me.

I believe that allowing young people to stay on their parent's insurance gives us a new freedom to work toward our goals without being uncovered. But, even more important than that is the fact that the Patient's Bill of Rights makes it so that I can't be denied coverage for a disease that I can't control having.

I can't put into words for you how scary it is to think about being 25 and bankrupt and sick. So, I'll just let you take my word for it, that it's absolutely terrifying.

I can tell you over and over how much health reform has positively affected my life, but I'm not the only young American that has been affected by this law. I'm one of millions and millions of young Americans who have been helped by this bill, whether through the dependent coverage clause or the Patient's Bill of Rights or a combination of both, like me.

I think a lot of the issue is that health care is something that's really easy not to think about when you're young and you're healthy. But eventually, we all get old, and most of us get sick. And when that happens, health care matters more than anything else; and I can testify to that because I've lived it.

Most people my age don't think about health on a daily basis, and to be honest, I'm kind of jealous of them that they don't have to. But, that also means that my generation doesn't fully appreciate just how much this bill works for them.

We are one of the first generations that's given access to free lifetime preventive treatments and care that will prevent life-threatening illnesses before they start. I think that Senator Hagan made a great point. You know, we need to make sure that young Americans know these things are out there, and that's why it is so important that you're holding hearings like this, and that groups like Campus Progress and Young Invincibles, who I've worked with, are getting the word out, because in order for us to win the future, as President Obama so artfully said on Tuesday, we need to have a generation of Americans who are healthy enough to do so.

This legislation makes that a reality.

And for those reasons I'm personally, and as a member of this country, extremely grateful that it was passed.

Thank you.

[The prepared statement of Ms. Schlichting follows:]

PREPARED STATEMENT OF EMILY SCHLICHTING

SUMMARY

At 19, after 2 years of unexplained symptoms, she was diagnosed with a chronic, autoimmune disease called Behcet's Syndrome. The disease affects the veins and can cause rheumatoid arthritis, as well as episodic flare-ups that cause open sores in the mouth, eyes, nose and throughout the body. Although Emily was covered due to her parent's insurance, it soon became apparent that health insurance would be a dominant issue in her life. The last few years have found Emily reconsidering what she can and will do with her life, a decision that's been influenced by her need to maintain health insurance. The political science and communications major at University of Nebraska has public service and non-profit ambitions, but knows the challenges posed by those jobs, which tend to not offer the best benefits. For Emily, being uncovered is not an option, so her choice was to go stay in school as long as she could to stay on her parent's insurance or try to find a job to start *immediately* after graduation. Now, thanks for the *Affordable Care Act*, Emily can stay on her parent's insurance until she's 26 and can seek the non-profit work she thinks will best serve her career aspirations.

Good morning, everyone. My name is Emily Schlichting. I'm 21 years old and live in Lincoln, NE. I am here today because my life has drastically changed for the better thanks to the Affordable Care Act. I would like to share with you just how health care reform has impacted my life.

The summer before my senior year of high school, when I was 17, I began experiencing a lot of odd symptoms, and none of my doctors could figure out what was causing them. My symptoms started as open ulcers that would get painfully and dangerously infected, and over the next 2 years intensified to include high-grade fevers, mysterious raised lumps on my legs, and swollen joints. After 2 years of visiting multiple specialists, receiving MRI's and CAT scans, which was topped off by a week-long stay in the hospital during my first semester of college, I was finally diagnosed with Behcet's Disease, a rare auto-immune condition. As you can imagine, this was a lot to deal with as a young 18-year-old barely out of my parents' house.

However, despite all that, I consider myself one of the lucky ones because my parents have amazing health insurance. My condition, because of that insurance, was completely covered. Being sick is hard enough in and of itself. Luckily, I didn't have

to worry about where my care was coming from or who was paying for it while *also* trying to adapt to a disease that has changed almost everything about my life. But when I did start to get my body under control, I realized that just because I had good health care under my parents didn't mean that being chronically ill at a young age was not going to impact my life.

When your health care is tied directly to your employment, your career opportunities become a lot more limited than you'd imagine. Suddenly, taking a few years off to work at a non-profit before graduate or law school was not an option because I would have dropped off my parents' insurance plan. Beyond that, I had to be extremely careful not to ever drop off an insurance plan because I have a preexisting condition, which meant if I dropped off I would likely not be able to get back on insurance. Paying for my own health care out-of-pocket would bankrupt me. I regularly see two rheumatologists, an ophthalmologist, a dermatologist, an internist and other specialists for my condition. And that's when things are going well.

But, thankfully, with the passage of the Patient Protection and Affordable Care Act last spring, none of that is an issue anymore. The dependent coverage clause has been a godsend for me; it allows me to stay on my parent's insurance until I'm 26; it gives me that buffer time to figure out what career I want to pursue, and work for a couple years to gain experience and valuable job skills. Then if I want to go to law school or grad school I will be better qualified and better prepared for a future career. Gaining that experience is something that is invaluable to me. I believe that allowing young people to stay on their parent's insurance gives us new freedom to work toward our goals without going uncovered. But even more important than that is the fact that the Patient's Bill of Rights makes it so that I can't be denied insurance simply because I have a disease I can't control. And that . . . it's changed my life in so many ways. I can't put into words how scary the idea of being sick and bankrupt at 25 is, so you'll have to trust me on this one. It's terrifying.

I can tell you over and over how much health reform has positively impacted my life, but I'm not the only young American that has been positively impacted by this legislation. I'm one example of millions and millions of young Americans who have been helped by this bill, whether through the Dependent Care clause or the Patient's Bill of Rights or the combination of the two, like me. Health care is something that is easy not to care about when you're young and you're healthy. But someday, all of us are not going to be young, and in my case, sooner, not so healthy. When that happens, health care becomes something that matters almost more than anything else. Most people my age don't think about their health on a daily basis (and I'm honestly a bit jealous of that). However, that also means that my generation cannot fully appreciate just how much this bill does for them. We are one of the first generations that will be given free access to preventive, life saving tests and treatments that can stop fatal illnesses before they start. Young people are the future of this country and we are the most affected by reform—we're the generation that is the most uninsured. We need the Affordable Care Act because it is literally an investment in the future of this country. This law is important. It's really important.

Thank you.

The CHAIRMAN. Thank you very much for a very poignant and passionate presentation.

Thank you for being here.

Mr. Koller, welcome. Please proceed.

**STATEMENT OF CHRISTOPHER KOLLER, HEALTH INSURANCE
COMMISSIONER STATE OF RHODE ISLAND, PROVIDENCE, RI**

Mr. KOLLER. Thank you. Chairman Harkin, Ranking Member Enzi and members of the committee, thanks for the opportunity to speak on this important topic.

I think my job here is to sort of give a view from the States—to speak from an implementation standpoint. I find that following this testimony that I've heard, it's just like my job at work; you listen to passionate stories and you end up having to work the machinery and enforce the rules behind the scenes.

So, it's hearing the testimony like this that gives us the fuel to do our work in the States. I'm going to talk about two things: A

review of how the States have implemented the Consumer Protection portions of the Affordable Care Act, and then try to talk a little bit about what the effects have been, at least in Rhode Island.

As Senator Reed so graciously said in his introduction, the office was created in 2004. What I want to emphasize is that in creating it, the Rhode Island Legislature gave it a broader charge than other kinds of insurance. They asked the office to look at, in addition to solvency in consumer protection, fair treatment of providers, and looking at the system as a whole and how to improve it.

I think that reflects what we've heard today, which is that health insurance is fundamentally different from other kinds of insurance. We don't ask our auto insurance to pay for our preventive health; to pay for our routine maintenance; and if you can't afford it, you simply walk.

We don't want to see that option for the kind of patients that we've talked about today; and I think the legislature recognized that in creating the Office of the Health Insurance Commissioner.

So, I want to speak to two things: How we've implemented the consumer protections, first.

Secretary Sebelius gave you an overview of the consumer protections, and when I begin, I want to say that I speak as an insurance commissioner. I am a member of the National Association of Insurance Commissioners; what I say here reflects my experience, of one insurance commissioner's experience. I'm proud of the NAIC's work, but what I say is not the official position of the NAIC.

As a rule, regulators have worked really hard to view this as an implementation task. We have a job to do; and we've been looking at what we have to do to implement these rules. It's nonpartisan. It's just what we got to do, given the laws that are out there.

When we've done this, what we've tried to do is look at the process that we have in place, existing; notably, our process of reviewing forms as they come in; the subscriber contracts.

How do we have to change the subscriber contracts to comply with the new Federal rules?

That has really been pretty easy. That's been modifying our check list.

Of a greater challenge has been refining the appeals process, working on implementing PCIP within our local laws, and doing rate review. I'm particularly doing this with tight State budgets.

The resources that have been provided to the States, particularly for myself, we have a small office, have been greatly appreciated. They allow us to jump start important work.

And where my—you asked for punch lines. So, my takeaway on implementation is that the guidelines and standards for the Affordable Care Act have to come from the Federal Government; they should be marked by clarity, consistency, constancy and sensitivity to local markets. Those processes haven't worked flawlessly to date, but I think that the Office of Consumer Information Insurance Oversight, the States, have been marked by mutually respectful competent and well-intentioned efforts that are meant to adhere to the statute, to implement it as it's intended.

I think Secretary Sebelius and her staff have shown admirable flexibility in working with these States to adjust to their local conditions and deal with transition issues as they go through.

But, implementation enforcement is up to the States. We are closer to the consumers, the providers, and the health plans. We can work more effectively through a series of relationships that we have; and I think that was the wisdom in the act that you passed, to leave that flexibility and that enforcement to the States.

Second, in terms of the effects of consumer protection, Senator Murray talked about rate review. This is something that we have worked really hard with in Rhode Island. We have a comprehensive rate-review process. The insurers have to come up with their rate factors that they're going to use. They have to be reviewed publicly, posted on the Web site. I collect testimony before I make a decision on what the rates can be, going forward.

The effect of this is to increase the accountability in the insurers, to have some stability, and to shift the focus of the conversation from how can I shift costs, how can I get rid of sick employees or sick enrolls, and how do we address the underlying costs to the system.

That's why we've been able to do—in Rhode Island, we've actually taken some of Senator Bennet's ideas from Colorado. Yesterday I had a conversation with commercial insurers about, how do we take the Colorado ideas around re-admission rates and put those things forward in our delivery system?

We can only do that because I have the authority of rate review. It means that when I speak they have to take into consideration what I say. The second point is, State variation and regulation. Rhode Island has to take relatively small steps to do this.

We had a lot of these measures in place. That is not going to be the same for our other States. We took a lot of grief doing this going forward. It's taken time. We have to be persistent.

We have to communicate consistently with our State offices, to help them understand what's going on.

But, as a result businesses, like Mr. Olivo's, have a stable market; they understand what's driving their costs; they have a choice of products with consistent rules for pricing. I can't emphasize how important that is, to change the rules for pricing from, how do I get rid of my high risk, how do I find someone who knows somebody who can get me a special deal, to focus on the underlying costs.

We know what drives health insurance costs for folks. We just have to decide if we want to be fair and allow people to be part of the insurance pool or not. That's what these rules put in place.

So, I'll just finish by urging you to keep, not only the individuals in mind, but the idea that we are creating a consistent set of rules, implemented at the State level, with flexibility, so that we can get at improving our underlying health system and allowing individuals to go forward with confidence in the way that we've heard about today; not to worry about, is health care going to bankrupt them going forward.

I believe that we did not get this right at the first.

I think we're going to have to make corrections going forward, but I think the trajectory is the right way to do it.

We continue to look forward to implementing the measures of the act going forward.

Thank you.

[The prepared statement of Mr. Koller follows:]

PREPARED STATEMENT OF CHRISTOPHER F. KOLLER

SUMMARY

1. IMPLEMENTATION OF CONSUMER PROTECTIONS

- Guidance and standards for the ACA has to come from the Federal Government. It should be marked by clarity, consistency, constancy and sensitivity to local markets. While that process has not worked flawlessly to date, it has been marked by professionalism on the part of States and Federal agencies and fidelity to the statute.
- ACA wisely left implementation and enforcement of these reforms to the States. We are closer to consumers, providers and health plans and can work more effectively than a Federal agency. States are working hard with limited resources to put these protections into place. In the wake of tight State budgets, the rate review and consumer assistance grants provided to States as a part of ACA have been greatly appreciated and the money wisely spent.

2. EFFECTIVENESS OF CONSUMER PROTECTIONS

- In Rhode Island we have in place a comprehensive health insurance rate review process that requires health insurers file the rate factors they anticipate they will use in all lines of business the coming year. These are posted publicly, analyzed, compared and debated before my Office renders a decision, which insurers have the option of appealing.
- Rhode Island has had to take relatively small steps to implement these consumer protections—our legislature has concurred with the Congress and previously had in place an appeals process, dependent coverage to age 25, and the disallowance of rescission language. Looking ahead we already have adjusted community rating in the small group market, as required by ACA and very limited allowance of pre-existing conditions.
- These reforms have made our health insurance market more stable, our pricing rules less susceptible to special deals that merely shift costs and reward the connected, and our vulnerable citizens more protected in the market. Small businesses in particular now know exactly the short- and long-term steps that must be taken to reduce the rate of increase in their premiums.
- You are less likely to hear from people who have benefited individually from these protections and from the more stable, accountable system of private sector commercial health insurance that is resulting. But I urge you to keep them in mind—because this is what you have created with the Affordable Care Act. I have no doubt that in statute and regulation we did not get everything right, and we will have to make corrections as we proceed. However, I am also certain that the trajectory of the ACA is the right one for citizens and we in Rhode Island look forward to the benefits it will continue to bring.

CONSUMER PROTECTIONS IN THE AFFORDABLE CARE ACT

Chairman Harkin, Ranking Member Enzi and members of the committee. Thank you for the opportunity to testify on this important topic. My name is Christopher F. Koller and I am the Health Insurance Commissioner for the State of Rhode Island. My testimony will be divided into two parts:

- A review of the process for implementing the consumer protection portions of the Affordable Care Act in States in general and Rhode Island in particular.
- An assessment of the effects to date of their implementation, and future implications.

By way of background: The Office of the Health Insurance Commissioner was created by statute in 2004. It is a cabinet level post and encompasses all aspects of commercial health insurance oversight in the State. We have a four-fold statutory charge which is broader than that given for the oversight of other types of insurance:

- i. Guarding the solvency of insurers;
- ii. Protecting the interests of consumers;
- iii. Ensuring fair treatment of health care providers; and
- iv. Seeing the health care system as a whole and directing insurers towards policies that promote system improvement.

This broad charge reflects the belief of the Rhode Island legislature that health insurance is fundamentally different in nature and social value from other types of insurance such as life or property and casualty. To the best of my knowledge there are no other insurance commissioners focused solely on health insurance in the country.

I am the first commissioner and assumed the post in 2005. Since then, our Office has focused on enforcing existing statutes, establishing a consistent, fair and transparent rate oversight system, and setting standards for health plan actions to improve the underlying performance of Rhode Island health care delivery system. I will speak of these activities in more depth later.

1. IMPLEMENTATION OF CONSUMER PROTECTIONS

Secretary Sebelius has given you an overview of consumer protections in the ACA. I believe my role is to speak to the experience of their implementation. As I begin, I want to note that my testimony reflects the experience of an insurance commissioner. While I participate actively in the National Association of Insurance Commissioners and am proud of their service in the States, and to Congress as it debated the ACA, nothing I say should be construed as an official position of NAIC.

As a rule, regulators found it most appropriate to view this as an implementation task, not a set of public policy questions—we have had a job to do. Thus, a priority of State insurance regulators has been on the measures—given existing State statute—a State must have in place to meet the statutory deadlines imposed in the ACA, many of which centered on commercial policies issued on or after October 1. The following have been the broad areas of enhanced consumer protections we have addressed:

1. First dollar coverage of preventive care benefits;
2. Elimination of lifetime and (in certain cases) annual limits;
3. Coverage of dependent children up to age 26;
4. Elimination of preexisting conditions exclusions for children;
5. Elimination of rescissions in individual coverage;
6. A process for consumers to appeal insurance company denials;
7. Disclosure by health plans of justification for rate hikes;
8. Development of minimum medical loss ratio standards; and
9. Develop preexisting condition insurance plans (varies by State).

In implementing these measures, regulators have relied wherever possible primarily on existing activities to review and approve health plan subscriber contracts (“forms”) and other consumer disclosures. In effect, we are modifying our checklists of what contracts must contain and permissible language. While this is not a nominal task, in our experience it has not been overly taxing. We have been greatly aided by the collaborative work of NAIC and good faith efforts by the Division of Consumer Insurance and Information Oversight to communicate continually to States what is needed and by when.

Efforts that involve changing processes other than forms review—such as refining the appeals process, developing medical loss ratio standards and implementing the PCIP statute—have been more varied by State and somewhat more challenging. In the wake of tight State budgets, the rate review and consumer assistance grants provided to States as a part of ACA have been greatly appreciated and the money wisely spent.

My message on implementation to date of consumer protections can be summarized with the following points:

- Guidance and standards for the ACA has to come from the Federal Government. It should be marked by clarity, consistency, constancy and sensitivity to local markets. While that process has not worked flawlessly to date, it has been marked by professionalism on the part of States and Federal agencies and fidelity to the statute.
- ACA wisely left implementation and enforcement of these reforms to the States. We are closer to consumers, providers and health plans and can work more effectively than a Federal agency. States are working hard with limited resources to put these protections into place.

2. EFFECTIVENESS OF CONSUMER PROTECTIONS

You have heard from individual consumers who can speak more powerfully to the effects of the ACA than I could. I would like to speak to two systemic effects of the act: the importance of rate oversight and State level variation.

In Rhode Island we have in place a comprehensive health insurance rate review process that requires health insurers to file the rate factors they anticipate they will

use in all lines of business the coming year. These are posted publicly, analyzed, compared and debated before my Office renders a decision, which insurers have the option of appealing. The effect is to increase accountability, and to shift the focus of the conversation from “how can I cost shift to improve my rate,” to “what is driving underlying health care inflation and how can it be addressed.” A sample of recent rate review analysis is enclosed in my testimony.

As a result, businesses in Rhode Island now have a public agency asking health insurers and providers the hard questions of what has to be done to reduce system costs, not merely shift them. Rhode Island is systematically investing in primary care, in health information technology and in provider payment reform, and leveraging the opportunities provided in those areas through the ACA and ARRA.

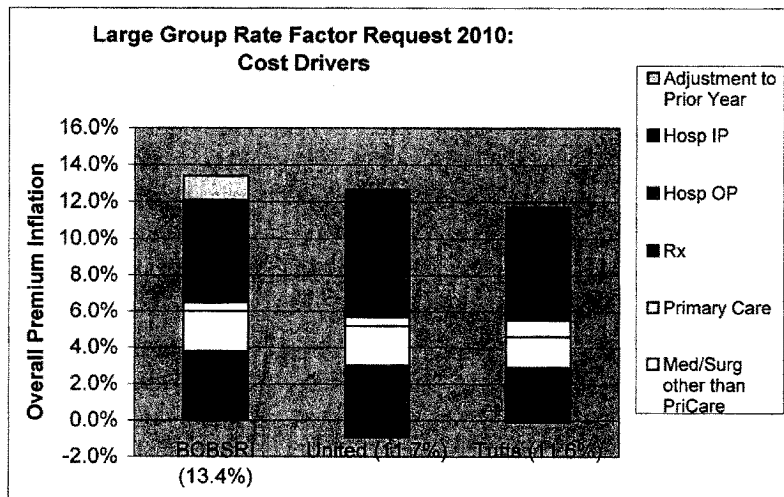
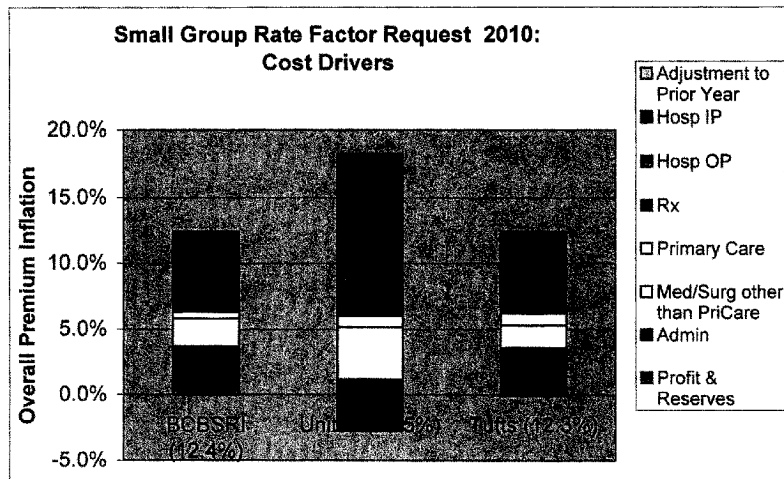
In the case of the increased consumer protections in ACA, having this rate process in place meant that health plans in RI had to state publicly how their costs would be effected by these changes in benefit levels and subject them to public scrutiny and analysis. OHIC could then make final, plan-specific decisions, and Rhode Islanders could be assured they were implemented systematically.

My second point is on State level variation in regulation. Rhode Island has had to take relatively small steps to implement these consumer protections—our legislature has concurred with the Congress and previously had in place an appeals process, dependent coverage to age 25, and the disallowance of rescission language. Looking ahead we already have adjusted community rating in the small group market, as required by ACA and very limited allowance of preexisting conditions.

These reforms have been implemented steadily over the past decade. They have not always been easy—particularly as the rules for pricing have become more transparent and defined—and have required patience, persistence and continual oversight. But they have made our health insurance market more stable, our pricing rules less susceptible to special deals that merely shift costs and reward the connected, and our vulnerable citizens more protected in the market. Small businesses in particular now know exactly the short- and long-term steps that must be taken to reduce the rate of increase in their premiums.

I should caution that even as the efforts of OCIHO to work flexibly with States continues, Members of Congress will hear from constituents about the implementation of ACA. Indeed, any adverse event experienced by anyone in the commercial insurance market will be attributed to the act, regardless of its true origin. You are less likely to hear from people who have benefited individually from these protections and from the more stable, accountable system of private sector commercial health insurance that is resulting. But I urge you to keep them in mind—because this is what you have created with the Affordable Care Act. I have no doubt that in statute and regulation we did not get everything right, and we will have to make corrections as we proceed. However, I am also certain that the trajectory of the ACA is the right one for citizens and we in Rhode Island look forward to the benefits it will continue to bring.

**Attachment 1:
RI Office of Health Insurance Commissioner**



Analysis: Projected increases in hospital inpatient and outpatient costs drive most of the rate factor increases requested by all three health insurers. Projected administrative cost increases are relatively large drivers for Tufts, while profit and reserve increases are significant for United and BCBSRI.

The CHAIRMAN. Thank you very much, Mr. Koller, and again, thank you for your tremendous efforts in getting here from Rhode Island yesterday.

Mr. Olivo, welcome, and please proceed.

**STATEMENT OF JOE OLIVO, PRESIDENT,
PERFECT PRINTING, INC., MOORESTOWN, NJ**

Mr. OLIVO. Good morning. Thank you, Chairman, and thank you to the committee for not only the opportunity but the honor to speak to you today.

I'd like to share with you my early experiences with the health care law, how it's already begun affecting my company, and some of the things I expect to see as the plan is fully implemented.

I'm the president and co-owner of Perfect Printing. The business was started in 1979. I co-own the company along with my wife, my two brothers and my mother. I have been running the company for the past 23 years. We've been very fortunate; we've been able to grow the company to a high of 54 employees prior to the economic downturn where we had to downsize; but we currently have 45 employees.

One of the main concerns I have with the health care law is how it's going to affect the coverage, the current coverage that I offer to my employees. I'm able to pay 100 percent of the premium cost for my employees, and 56 percent toward their dependent costs.

The reason we've been able to do this is by the use of a high deductible health savings accounts plans. Now, I know during the lead up to the passage of this legislation, we heard numerous times, and my employees heard numerous times that they would be able to keep the health care that they had.

Within 30 days of the passage of the legislation I received a letter from my insurance carrier that our plan would no longer be offered. It's my understanding that because of the preventive care portion of how it's treated with high deductibles, it was no longer in compliance with the health care law. So, as far as I'm concerned, that has proven to be untrue.

Another area of concern for me is the tax credits that have been promised to small business in order in which to pay for this. Now 45 employees were certainly larger than a lot of small businesses, but I don't think anyone would describe my company as a large company. There are zero dollars in tax credits available to our company.

I've had conversations with other fellow small-business owners; I was speaking a couple of weeks ago to the owner of a three-employee bridal shop that had spoken with her accountant. She is not eligible for any dollars in tax credits. So, I don't anticipate that being of assistance to my business or to my employees.

A third area which is of great concern to me is compliance with the 1099 law. This law, as you know, requires me to submit a report for every vendor that I spend accumulated expenses of \$600 or more per year. Simply put, I do not have the systems in place to monitor this. This will require myself as a business owner, monitoring this and waste my time monitoring receipts and keeping track of this. To put it in perspective of a small-business owner, in a good year my profits are 3 cents on every dollar earned.

Every time there's a new legislation, a regulation from Washington like this, a good portion, if not all of that, comes out of the profit of my business. It affects my ability to give my employees raises and pay for future benefits.

Then there's the issue of whether I should even decide to grow my business at the—we are 45 employees; if I go over the 50 employee threshold, where we were just 2 years ago, it's my understanding that I'm mandated to provide insurance, or I would have to face a penalty for not providing that insurance.

It's also my understanding that I could possibly be penalized even if I do provide insurance. So, I find the ironic part about this portion of the law is that what it's supposed to encourage or mandate employers to provide insurance, I guess when you look at the cost of the penalty that is currently in the legislation versus what I pay for premiums, is actually an incentive for me not to provide insurance for my employees.

These are the issues that I know that are currently affecting my business.

It's the unknown that's even more of a concern. To put it in perspective of myself and a lot of small-business owners, when I decide to grow the business and invest funds and take a loan out, I have to know cost certainty, because I put my house on the line; I put my family's house on the line; I put all my personal assets on the line. I cannot afford to be wrong with my assumptions.

So, when you have a health care law like this with so much unknown—and I challenge anyone to say, “Well, here's what your health costs will be 2 years from now,” it causes me to be much more hesitant to invest my money.

I think you're seeing the accumulative effect of this in why small business is not participating in the growth of the economy.

So, I'll leave you with this: My story is personal; it is by no means unique; there are hundreds of thousands, if not millions of small-business owners going through the same issues that I am right now.

Thank you.

[The prepared statement of Mr. Olivo follows:]

PREPARED STATEMENT OF JOE OLIVO

SUMMARY

1. Welcome Remarks
 - a. Share experiences & additional consequences.
2. Background
 - a. Company description/size.
 - b. Health insurance background.
 - c. State of New Jersey.
3. Inability to Continue Existing Coverage
 - a. Currently offer plan that pays 100 percent premium.
 - b. Offer additional plans.
 - c. High deductible plans have controlled cost increases.
 - d. High deductible plans create better decisions.
 - e. Existing Coverage No Longer Offered.
 - i. Due to preventative care mandate.
 - f. Cannot keep our existing coverage.
4. Non-Eligibility for Tax Credits
 - a. Temporary, to narrowly limited and of marginal assistance to most owners that I know.
5. Effects of 1099 Compliance
 - a. \$600 or more.
 - b. Huge burden, no system currently in place.
 - c. Significant drain on already limited resources.

- i. Cannot hire consultants or additional employees.
- d. In the context of a small business owner.
 - i. Small profit.
 - ii. Lack of time.
- 6. Negative Consequences of Going Over 50 Employees
 - a. Threat of penalties if I exceed the 50 employee mark.
 - b. Actually an incentive not to provide insurance as the penalty is less than the current premiums that I pay.
- 7. Consequences of Cost Uncertainty Due to the Law
 - a. Hesitancy to invest because personal assets are on the line.
- 8. Concluding Remarks
 - a. Personal but not unique.
 - b. Economy cannot prosper for all by stifling a main engine of growth.

Good morning. I'd like to thank the committee for the opportunity and honor of allowing me to present my testimony today. My name is Joe Olivo and I own a small business. I appreciate the willingness to have an open discussion about some of the concerns that I, along with many of my fellow small business owners, face because of the new healthcare law. I would like to share with you my early experiences with the law, how it is already affecting my business and what additional consequences I expect to see as the regulations are fully put into place.

I am the president and co-owner of Perfect Printing. I own the company along with my wife, my mother and two brothers. My parents started the company as a literal "mom and pop" copy center in 1979 and I have been actively running the company for the past 23 years. We have been fortunate in that we were able to grow the company to a high of 54 employees prior to having to downsize during the recent economic downturn. We currently have 45 full-time and part-time employees.

One area I am certain will have a profound effect on my business is the new, expanded 1099 reporting requirement in this law. As you may know, the law now requires that I submit to the IRS a report of any transaction adding up to over \$600 in business in a year. This is a huge requirement and I do not have any sort of system in place to account for it. Just to give you a couple of examples, I have drivers and sales people that fill up for gas. Based on a quick calculation, I estimate they have probably gotten over \$600 in gas at 8 to 10 filling stations. I will now have to track down who the gas station owners are, get the proper information and submit to them a form of how much we spent with each business entity. Another example is the salesperson or owner who frequently travels. Can you imagine trying to submit paperwork to the various airlines, hotels, rental car agencies and restaurants that you visit over the course of a year? I will most certainly have to purchase some sort of software program and waste my resources calculating and collating receipts for purchases of thousands of items. I think it is very important to keep in mind the huge costs that additional regulatory burdens place on small businesses like mine. My business, like most small businesses operate with a very tight profit margin and with little extra money to spare on purchases that do not directly affect the profitability of the company. In a good year, our profit is 3 cents on every dollar earned. Many years it is less than that. When additional regulations, like those contained in the healthcare law, are instituted the cost to comply with this usually comes out of the profit portion. I do not have the luxury of simply creating new revenue or cutting additional expenses in order to afford the costs to comply. Besides the cost there is the issue of the availability of time. As a small business owner, I have to make decisions daily as to what issues can be attended to by the end of the day and which ones will have to be pushed off to the next day simply because I run out of time. My business can't afford the luxury of hiring an HR or accounting consultant, or a new employee to fill out all of the new government paperwork that is required by this law. Simply put, if this part of the legislation is not rescinded this will impair by ability to grow my business and the same would apply to the millions of other small businesses in this country.

A key issue for any employer is how and when to grow their business. Our company is on the cusp of the 50 employee threshold, at which I would be legally bound to offer my employees insurance or pay a penalty if I do not. Besides being ridiculously complex, it is my understanding that, at the 50 employees or greater mark, I could possibly be penalized even if I do offer insurance to my employees and one or more of them decide to take a government-subsidized plan. I am still in the process of trying to compute the exact ramifications of this portion of the law. This being said, in the event I do hit that 50 employee threshold, based on my current pre-

miums it may actually be less expensive for me to not provide any health insurance and just pay the penalties. Ironically, the part of the law that mandates that I must now provide insurance is actually providing the perverse incentive for me not to provide any insurance at all. This would not only be more expensive to the Federal Government but it would mean that my employees would lose the administrative support that I offer them with their health insurance.

One of the main concerns I have with the law is how it will affect the current healthcare coverage that I already offer to my employees. We currently offer a plan where the company pays for 100 percent of our employees' insurance premium and pays 56 percent toward family coverage. We are also able to offer our employees additional plans that offer lower deductibles at a higher premium cost. Compared to a lot of our competitors we think this is quite substantial. We have only been able to do this by offering a high deductible plan with a health savings account. We began offering this plan 6 years ago and it has been a tremendous tool toward slowing the rate of the escalating healthcare premiums that we face, especially since we are located in New Jersey. New Jersey is a guaranteed access, community-rated State with heavily mandated policies. We have seen double-digit percentage increases to our annual premiums going back to 1993. I estimate our average premium increase for the past 17 years is around 20 percent each year. The high deductible plans have allowed us to continue to pay for our employees' premiums. With the savings to the company from offering these plans, we have been able to contribute to the employees' health savings accounts while encouraging the employees to do the same. I have seen how these plans encourage healthier lifestyle choices and make everyone more accountable and aware of how they spend their healthcare dollars. While I would not say high-deductible accounts are the sole answer to the crisis of rising healthcare costs, it has been a very effective tool for my company.

During the debate leading up to the passage of the legislation, I heard numerous times that my employees would be able to keep the same plan they currently have. Unfortunately, within less than 30 days of the law's passage, I received a letter from our insurance carrier notifying us that our plan would no longer be available at the end of the current term. The reason for this is that the preventative care portion of the plan did not meet the requirements of the new law. The promise that my employees would be able to keep their existing health insurance has proven to not be true. After 20-plus years of voluntarily providing coverage for my employees, much of it at my own cost, I am now finding out this coverage is no longer acceptable according to the government.

A final area of concern to me is the tax credits that were promised to small business in order to help them pay for health insurance. This point was made over and over during the debate and even persuaded some of my fellow small business owners to mute their criticism of the plan in the hopes that maybe the legislation would be a net benefit to their companies. The problem with the tax credit is that it depends on the government's definition of small. I checked the tax credits that I am eligible for and I come up with a big fat zero. Now at 45 employees there are certainly smaller businesses out there but I don't think anyone would consider us a big business. I have learned from fellow business owners with much smaller companies that the tax credit is so narrow and so limited that it would provide marginal assistance to a very low percentage of small businesses that are out there. For example, an 18-person business who pays, on average, \$38,000, doesn't get anything either. Beyond this, the credit is temporary and, as I referenced earlier, the year over year increases in healthcare costs certainly aren't.

While those issues that I have mentioned are the known items that will affect my ability to grow my business, it is the uncertainty that causes concern as well. Questions such as:

What portions of the legislation are applicable to my company?

What are the exact ramifications if I go over 50 employees?

What taxes, fines and penalties will I be exposed to? How much will they be?

Will I need to hire outside consultants or new employees in order to see that I am in compliance with the new laws?

What is the definition of a part-time employee?

You should understand that when I make the decision to invest in my business and try to grow it further, I cannot afford to be wrong in my calculations. Like most small business owners, I put my home and a good deal of my personal savings on the line when I make these investments. When there is so much uncertainty regarding the costs that will be required of me to comply with these new laws, it makes me much more hesitant to invest and causes me to take much less risk in those investments that I do wish to proceed with.

My story is very personal but it is not unique. There are hundreds of thousands, possibly millions of small businesses owners that are facing these same issues. How can we make the economy prosper for all when we are stifling one of the main engines of growth? Thank you for the opportunity to testify today. I look forward to answering your questions.

The CHAIRMAN. Thank you, Mr. Olivo.

Thank you, very much. Again, we'll start with 5-minute rounds.

First, Ms. Grasshoff, again, thank you very much for telling the story about your son, Joshua.

You mentioned that your husband was forced to change jobs, to take one that paid less money; and so were you. I'm just curious about how that affected your family's financial security; and obviously, you have to be looking forward to your own retirement years and that type of thing.

I just wondered how that might have affected your own personal financial security.

Ms. GRASSHOFF. It affected it tremendously. It reduced our income by approximately 40 percent, but yet our bills didn't decrease by 40 percent; and I'm just speaking of the necessities: The groceries, the gasoline, you know, utility bills.

It really took away from any outside activities that we would do as a family, such as, going to the matinee movies. We had to be very, very frugal.

You do what you have to do. The health insurance was the most important thing.

The CHAIRMAN. Now, is Joshua aware of the health care law and how it's going to affect him?

Ms. GRASSHOFF. Yes, sir. He absolutely is aware of it.

The CHAIRMAN. So, this is just giving him a little bit more security that he can go ahead and do things in his own life?

Ms. GRASSHOFF. Yes, yes, it is. It has given him a lot more security, because he sees that it's given his dad and I the security and the peace of mind, knowing that he will be covered on a health care plan until he is 26.

Unfortunately, he's not yet been able to start college, due to some medical issues; and he's looking forward to starting college. This gives him a little more time to decide.

He might go to school for a year and then want to be a rock musician or what have you.

The CHAIRMAN. Horrors.

Ms. GRASSHOFF. But it gives him security, and, his dad and I security, knowing that he will have coverage.

The CHAIRMAN. Or like Ms. Schlichting, maybe he might want to go to work for a nonprofit or do something generously—

Ms. GRASSHOFF. He very well could. I would love for him to follow in my footsteps.

The CHAIRMAN. Ms. Schlichting, I was reading the press release that happened to be in the *Omaha World Herald* about your appearance here.

You were quoted as saying, "It's not just middle-aged families who are affected by the reform," Schlichting said, "It's about America's young people."

Ms. GRASSHOFF. Absolutely.

The CHAIRMAN. The largest group of uninsured Americans. So, Ms. Schlichting, I think you put a finger on it. Not too many people

think about the young people that are affected by this; and I think you give evidence of what it means to young people.

Ms. SCHLICHTING. I would definitely agree with that; and that's something that I see a lot, just like at home, with my friends and the girls I live with in my sorority. I remember when this law was passed, standing in the kitchen at breakfast, being like extremely excited; and no one else around me had any idea what it meant, and how big of a deal it was; and I think it is because, as has been touched upon earlier, young people are, by and large, very, very healthy.

They're a healthy demographic, which is wonderful; but as my existence proves, that's not the case for everyone.

There are young people who get sick. There are young people who get really sick. Giving this security to them at that age that gives them stability at a young age so they can go on and do productive things with their lives, I think it's wonderful; it's great.

The CHAIRMAN. I think you put your finger on it; when you're young, if you haven't had an illness, like you have, young people never think they're ever going to get sick, or they might—

Ms. SCHLICHTING. Oh, yes, not at all. I mean, yes, that's definitely something amongst all my friends there. It's another part of why it is hard to be ill as a young person, because your peers really can't relate to you.

Like, I can't tell you how many times I've been called like, oh, "You're acting like an old woman," and because I'm like swollen joints and don't want to go out that night, kind of a thing, and when—you get used to it and you deal with it. But, yes, it's definitely something that I would say most young Americans don't have flying on their radar.

The CHAIRMAN. Right.

Mr. Olivo—I'm going to skip over Mr. Koller here just briefly, but, Mr. Olivo, by 2014 every State will have an insurance exchange; a one-stop shop for small businesses like yours that can pool their purchasing power to get the same leverage on insurance rates that large corporations have.

Now, as I've looked at that, and as I've discussed it with small businesses, their first question to me was, why do we have to wait until 2014? If we'd have had that now it would be a lot better. It just had to do with the way that legislation is done around here, I guess and compromises that are made.

I just wonder, have you looked down the road at how that might affect you in 2014 and your employees; what that exchange system might mean to you in 2014?

Mr. OLIVO. I've looked into it because I have no way of knowing what the costs are going to be. My concern with any exchange is that it's set up as a true competitive exchange.

My understanding with the law is that the policies being offered will still be very heavy in mandates, and preventive care items that don't really open up to true, it's not a truly competitive product I'll be buying. That was one of the things we have with high deductible HSA plans for my employees that fit our demographic of our company, and I was able to provide a plan that was best for them.

With the exchanges, I'm not sure it's going to be when it's—I'm from New Jersey where we have one of the most heavily regulated

insurance systems in the Nation, very heavily mandated, and we have, I believe it's in the top three of insurance premiums in the country.

I'm not very optimistic that a heavily-regulated mandated insurance exchange will be of benefit to me.

The CHAIRMAN. Well, again, companies will have to come on the exchange and compete for business.

Plus the fact, as you know, we also are mandating that, I think the Secretary testified to that earlier, that as of January 1 of this year, insurance companies have to put 80 to 85 percent of each premium dollar on health care quality improvement. So, they have to start meeting that threshold right away.

It seems to me in that regard, that, coupled with the number of exchanges out there, even though there are mandates, for example on the prevention side, the reason we mandate on the prevention side, is because we know, from all the evidence, that an ounce of prevention is worth a pound of cure. If we put more in the front end, it's going to save more in the back end. I mean, everybody understands that.

We're trying to move to a system whereby people get more up front interventions early on so they don't get in the system later on. That's why we have that entered on the wellness and the prevention end of it.

We were hoping, and I don't know, we'll have to wait and see, but I was hoping that, as we pass this, that we might have some really true competition now out there, and these health insurance policies that come on the exchange will be transparent; people will know what they are.

Your business might be on the exchange with others that can join together and actually get lower costs but higher quality; because everyone's going to be competing for your dollar. Right now, I don't know that that's really true, right now in the present system that we have.

If you have any response on that, I don't know.

Mr. OLIVO. Yes. I mean, I like the opportunity of buying out of State. Once again, from my perspective as a business owner in New Jersey, I've been running it since 1988.

In 1993 our State went to a guaranteed access community rated insurance policy; and the politicians in my State have been promising for the last 18 years that our premiums would go down as a result; not 1 year has our premiums gone down.

The CHAIRMAN. Thank you, very much. I went way over my time, and I apologize.

Senator ENZI. Thank you, Mr. Chairman. I thank the panel for their testimony. I'm going to concentrate on trying to figure out what we need to do to eliminate unintended consequences of the new law.

I appreciate Mr. Koller's comments. Thank you, Mr. Koller. I appreciate that you have a brother in Greybill, WY, so you must have a little understanding of our rural area.

But, I will be asking, in writing, for you to list out those fixes that you see as being needed; and I appreciate that you mentioned that.

One of the comments that I get from people in Wyoming is that there's this new high-risk pool; but they can't get in the high-risk pool unless they go without insurance for 6 months; and they can't afford to go without insurance for 6 months because they have problems similar to what we've heard about today.

I want to get a little bit of clarity on some of these things.

Mr. Olivo, you said that the 1099s—and as the accountant in the Senate, and I'm now joined by Senator Johnson, who's also an accountant, so we'll have an accountants' caucus—I am familiar with the 1099s.

I wondered if you had any evaluation on what the potential cost is for you on those 1099s, with the equipment and things that you might have to put in or hire a person. I know it's early for you to do an evaluation on that, but do you have one?

Mr. OLIVO. I don't have an exact dollar cost, but just to give you an idea from my perspective, I can't afford to hire an HR consultant or an accounting consultant; that's going to come right out of my profits. So, I'm going to have to do it myself, as a business owner, or assign someone internally that's going to take away their productivity.

Just to give you an idea: My trip down here, I took a train, I took a cab, I stayed in a hotel. I have to monitor, did I go over \$600 staying in Marriott Hotels this year? Is it franchise-owned? Is it corporate-owned? Try to track down who the owners are, send them the proper documentations. It's just a logistical nightmare that I can't imagine even having to do.

Senator ENZI. I really appreciate that, and I know that the purpose of it, supposedly, was to find \$16.9 billion in fraud that people are doing; and as an accountant, I can't figure out exactly how that's going to do that; but my calculations of cost, to find that \$16.9 billion for the Federal Government, it's going to cost individual businesses about \$25 billion to collect the information. That's not cost-effective.

I noticed in your testimony that you obviously have looked at the 2,700 pages, and I appreciate—or whatever of them you were able to go through. I know as a small businessman—and I was in the shoe business for years and years—that it's difficult to keep up with the Federal Government; but I appreciate that, in your testimony, you had the five questions in there that are pertinent for a small business, because we don't look at these things from a small-business perspective very often.

I wondered if you wanted to enlarge on those just a little bit or mention them? I will be checking on all of those answers for you, and appreciate that you were able to list them out so concisely.

Now, in this job market that's been decimated and shed millions of jobs, you spoke about the health reform law making you think twice about hiring new employees.

We know that almost $\frac{2}{3}$ of jobs come from small businesses, so if we're going to see our economy recover, it's the small businesses that will lead the way.

But, as you point out, the health reform law created a very large tax penalty for small companies that can't afford to provide health insurance for their employees. So, can you expand a bit on your

concerns about hiring new employees as a result of the health care reform law?

Mr. OLIVO. Certainly. Just to give you an idea when there's uncertainty—and some of the questions I had put in, is: Just what portions of the legislation are applicable to my company; exactly what happens if I go over 50 employees; if I have a part-timer; if he's 30 hours or 20 hours? All these questions add up to costs.

When I invest in my business, when I hire new employees, I take a loan, and that payment is fixed. I have to pay that loan every month. The bank doesn't want to hear, "Well, I'm sorry, I made a little mistake in my calculations; I can't afford it this month."

When you have all this uncertainty and all this unknown, it just creates a much bigger cushion, of which I chose not to invest. It affects, not just my business; it affects my employees. I can't give the amount of raises I want to give. We haven't had a raise in our company in 2 years. And, it makes it that much more difficult to grow the business.

Senator ENZI. I can certainly understand that and appreciate it.

You were asked the question a little bit earlier about the exchange creating pooling that will bring down your costs.

The way I understand the exchange is, there will be a place on the Internet that you can go to, and you can put in the different criteria of your business, and you will be shown the list of companies that will be able to sell you insurance, because they will meet the Federal minimum standard.

I don't see how that's going to drive down the health care costs for small businesses. But, I've had a bill that will allow small businesses to actually pool their purchasing power across State lines to buy less-expensive coverage, and the CBO said that would slash premiums.

Do you think the costs of your health insurance will decrease if you are able to get into this exchange?

Mr. OLIVO. As the exchange is currently set up, I'm not optimistic. I'm a little leery of it because it's not true competition when it's a mandated product.

We've had the same thing in New Jersey for the past 19 years. It was supposed to be that there's a lot of heavy mandates and preventive care costs, and I have not seen—my average premium increase in the last 10 years has been 20 percent; and it ranges from 12 percent to 49 percent on any given year.

So, I'm just leery. I've seen what mandates have done to our State insurance costs, and I'm just a little leery when I see the same type of thing on a Federal level.

Senator ENZI. I appreciate that, and I would mention that in the HELP Committee bill, Senator Harkin and I had an amendment that would have allowed for some flexibility for incentives, which could have provided for some preventive care; I did notice that that was accepted by the committee; I did notice that after the August recess, when the bill was actually printed, that part of it was no longer in there. So, pieces of that amendment were deleted.

Thank you very much for your testimony. I will have more questions for all of you in writing and hope that you'll answer them.

Thank you.

The CHAIRMAN. Thank you, Senator Enzi.

Senator Reed and then Senator Franken.

Senator REED. Thank you very much, Mr. Chairman.

I, too, want to thank Commissioner Koller for braving the elements to come down here. You left out the dogsled.

[Laughter.]

Train, but the dogsled was the final thing.

Commissioner Koller, one of the issues we've been talking about is ensuring that this system covers everyone in the State; and from your perspective as Commissioner, how important do you think that is, in terms of both delivering effective and cost-effective health care service?

Commissioner KOLLER. Thank you, Senator Reed. In our State, we have seen our rate of uninsured, the percentage of people uninsured in the last 6 years, go from 6 percent to about 14 percent. That is completely an effect of the economic downturn, which, as you know, and have worked hard with us, affected Rhode Island particularly severely.

It is not a result of increasing health care costs; that certainly has contributed to it. But, those people who are uninsured, we still pay for.

When I look at a rate—and this is the benefit of a comprehensive rate review—when I get a rate request, an annual estimated inflation of 12 percent, and then about 4 to 5 points of that is the hospital; and then when I go and I ask the health insurers what's that about, they say, "Well, we've got to pay the hospitals 9 percent more in price increases"; 1 percent for utilization, but 9 percent in price increases.

I ask, "What's that come from?" They say, "That's from the number of uninsured." The hospitals have not gotten paid for their uninsured, so they're looking for commercial insurers to make up the bill; and, so, we pay for the costs of the uninsured. I also think we pay, long-term with poor public health.

You and Senator Sanders, have been strong advocates for community health centers; for having comprehensive primary care. That has to be the point of entry for this.

Uninsured people are not getting good primary care. It's not clear that commercially insured people are getting good primary care. That is what has to be our focus.

Senator REED. In effect, one consequence of not covering everyone is that the uninsured will get health care, but expensively, through hospitals, and that has shifted, as you point out as Commissioner, directly to private insurance companies, who, in turn, recoup that from their customers.

These 20 percent, as Mr. Olivo pointed out, these 20 percent, 40 percent increases every year are in many respects traceable exactly back to the fact that we've got a whole group of people who have no coverage but still get care.

Commissioner KOLLER. Yes. And if you look at who the uninsured are, by and large, they are working, single adults who, if they could afford health insurance, would buy it; but they are making an economic calculation based on their circumstances, to go bare.

Why are they doing it? Because affordable health insurance isn't available; and because they're given the option to opt out, absent a mandate.

Those are exactly the working uninsured, who comprise the majority of the uninsured, are exactly the folks we want in the pool to make it work.

Senator REED. One of the other things that we've got to do is not simply sort of fund this system; it's to reform the delivery of health care.

In your capacity at the Neighborhood Health Plan of Rhode Island, and in your capacity as Commissioner you've got a unique perspective: You've actually run an HMO health insurance company and now you regulate them.

What are some of the delivery improvements that you've seen already in Rhode Island; and will they be promoted by national health care reform or accelerated? Are there other things that are going to be possible?

Commissioner KOLLER. The most important thing that I feel that we've done in Rhode Island in the commercial health insurance market, is to say to health insurers, if you want to work in this State, if you want to get the rate increases that you're seeking, you have to put more money into primary care. Primary care is the only part of our delivery system where the more we have, the lower our costs are and the better our health is.

Yet we systemically pay it less over time, led primarily by the historical way that we've determined rates within Medicare.

We have told the commercial and health insurers that we spent 6 percent of our insurance premiums on primary care—only 6 percent. If you look at other countries, it's 15, 20, 25. There's no way that we're going to deliver you lower costs if we don't—over the long-term—put more money in primary care.

I think the other thing is to change the way the hospitals get paid. It is not in the hospital's financial interest to reduce their readmission rate. That is money in the bank. So when you go to health in hospitals and you say, 20 percent of your Medicare patients are being re-admitted, they say, "Yes, I know, and for me to work on that is financial suicide." So, we have to change the way that we pay them.

There are absolutely things within the Affordable Care Act. The investments in community health centers, in the National Health Service Corps, in patient centers, Malcomb Home Demos within Medicare, changing the way that hospitals get paid. We need that kind of Federal leadership so that we can tell the commercial health insurers, Do the same thing in the States.

That's how we get at the underlying costs.

Senator REED. Again, I thank you. My time's expired.

I thank the Chairman and Ranking Member. This has been a very informative hearing; and I particularly want to thank you, Chris, for joining us; and to all the witnesses, for your firsthand testimony.

And, go, go, Cuskers? Is that the right term?

Ms. SCHLICHTING. Go, Big Red.

Senator REED. Go, Big Red, OK. All right, take care.

The CHAIRMAN. Big Red. I just want to clear up one thing, if you don't mind:

Mr. Koller, you said that 6 percent went to primary care; is that 6 percent of the premium dollar?

Mr. KOLLER. Six percent of the premium dollar goes, actually, it's even less than the premium dollar, because it's 6 percent of medical expenses. So, it's 6 percent of the 80 or 85 or 80 percent goes to primary care over time, and yet—it has to be absolutely at the core of any kind of delivery system reform.

I would say, Senator Enzi, to your point: My brother and I have spirited conversations about the difference between Rhode Island and Wyoming, and the fact that you can fit the entire State of Rhode Island into one of the counties up there. But I have this healthy respect for the importance of flexibility in terms of how States implement this.

They recognize, in Wyoming, and any place, the importance of primary care.

That doesn't change. That's not something that we can be flexible about.

The CHAIRMAN. Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman.

Thank you, all of you, for your testimony; Ms. Grasshoff for your testimony about your son, Joshua; Ms. Schlichting, for speaking about the importance of what we're doing in terms of not discriminating against people with preexisting conditions; Ms. Grasshoff about the importance of lifetime caps.

Commissioner Koller, Rhode Island can fit into most States—counties, OK?

[Laughter.]

So, give it up about Wyoming.

Mr. Olivo, thank you for your testimony. My dad worked for a great printing company for 30 years, in Minneapolis, Johnson Printing, as a printing salesman. We got our health insurance through Johnson Printing. We got great health insurance for our family.

Your testimony about the 1099s, both here and in your written testimony, this is why I've co-sponsored an amendment or bill to actually get rid of that burden; and I think we will.

So, thank you, and thank you for contributing to our understanding of that.

Now, you wrote in your written testimony, that your health care insurance premiums increased by an average of 20 percent a year over the last 17 years; is that right?

Mr. OLIVO. That's correct, and what I mean by that, is, for renewing the same type of policy, it would typically come in, on the average, around 20 percent over a 10-year period.

Senator FRANKEN. OK. Over a 10-year period.

Mr. OLIVO. Annually.

Senator FRANKEN. Annually, OK, that's what I was looking at.

That happened when there was no health care reform at that point.

Now, what if I told you that monthly premiums for Massachusetts's businesses, after they passed their health care reform, which mandates the same stuff that this mandates, that the

average monthly premiums rose, on an average of 6.9 percent from 2006 to 2007, and by 5 percent from 2007 to 2008? Would that be better than the 20 percent that you're—

Mr. OLIVO. From simple economics, that would be better, certainly.

Senator FRANKEN. OK. That's what happened.

What if I told you that in Massachusetts, after they imposed the mandate that a percentage of Massachusetts employers who offer health insurance to employees, has increased to 76 percent from 70 percent, while during the same period, nationally, it declined from 68 percent to 60 percent during the same period; might that give you some hope?

Mr. OLIVO. Once again, coming from New Jersey where I've heard these tale of mandates and for 18, 19 years, saying, we're going to mandate and legislate—we're going to legislate our way toward lower premiums, I haven't seen it happen in my experience where that's to be the case.

Senator FRANKEN. But, the Massachusetts mandate is almost exactly, precisely what the national mandate is.

And, do you understand for someone like Ms. Schlichting, if there wasn't a mandate, that it would be impossible to provide protection for people with preexisting conditions because then only people with preexisting conditions would get health care? There would be no reason to get health care until you got sick; right?

Mr. OLIVO. I certainly understand that. From my point of view—and keeping in mind I'm a small business owner who pays 100 percent of my employees' premiums.

Senator FRANKEN. Right.

Mr. OLIVO. I'm worried about telling my employees, I can't afford your position anymore because of the new health care law. So, I'm well aware and I understand the problems. I'm just concerned for my own employees right now.

Senator FRANKEN. I'm sorry. I'm sorry. Why do you provide health insurance, you're not mandated to do so, for your employees?

Mr. OLIVO. Like any other expense, I look at it as an investment. I've chosen to invest in my employees this way; I think it's a good investment. I wouldn't presume to tell another business owner how they should invest. I would definitely say, by choosing to do this, it has affected my business' ability to grow, because I choose to forego other investments that could grow my capital, because I've chosen to do this for my employees.

Senator FRANKEN. But, you feel it's better for your business.

Mr. OLIVO. For me, personally, it is.

Senator FRANKEN. OK.

Mr. OLIVO. I think it's good business for me.

Senator FRANKEN. OK. So, now, suddenly, when there was a penalty that you'd have to pay if you dropped them, why would that incentivize you more to drop them than you've had before? That doesn't quite add up to me.

Mr. OLIVO. My competition begins doing it, and that's a very real possibility; and they all of a sudden have a less-expensive expense structure and are gaining profitability, where I don't have it. It's natural capitalization at work—it's something where I can't ignore

because it will negatively affect my company's ability to have my employees further prosper.

Senator FRANKEN. I understand. And, you're aware in Massachusetts there is a penalty, and it very much parallels this bill, and yet, contrary to the rest of the country, since Massachusetts has adopted its mandate, more companies, more employers are insuring their employees in complete opposition to the rate in which it goes in the rest of the country, which is less companies have—a lower percentage of which have been insuring their employees in a way that would then mean that you don't have to compete; you'd have to compete against fewer companies that weren't insuring their employees.

So, it would help your competitive advantage, considering that you're already someone who does the right thing; and I applaud you for that.

Mr. OLIVO. I've read things about Massachusetts that aren't working out well. I live in New Jersey, I don't know enough about Massachusetts to really comment on it; I could just say as a small-business owner, with the way this legislation is set up right now, I only see rising cost to my company. I don't see where I'm going to gain lesser expense.

Whether that may happen and time bears it out, that could be. I just don't see it.

Senator FRANKEN. OK.

Thank you, really all of you, for coming today. My time has expired.

The CHAIRMAN. Thank you very much, Senator.

I thank, again, all of our panelists who are here, for their very personal and poignant testimonies, for their professional testimonies, and also how this is affecting small businesses, who are really the people that employ most Americans.

I agree that we're going to do something about the 1099. I've said many times before on this Health Reform bill, these are not the Ten Commandments written in stone; it's the law; it's the law that's in effect. Laws get changed. We modify things as time and circumstances, and as information comes to us.

I've often referred to the Health Care Reform bill as a starter home. It's got a pretty good foundation; it's got a pretty good roof, but maybe there are some other things that need to be filled in and built into it.

That's why sessions like this are, I think, important for us to hear from people about some of the good things, or maybe some of the questions that people have that we should be paying attention to, as we move ahead, as we probably modify, change things as we move into the future.

Again, I thank you all very much for being here, and thanks for your excellent testimony.

If there's no other business, the committee will stand adjourned.
[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF SENATOR MIKULSKI

Chairman Harkin, I thank you for organizing today's hearing that focuses on the consumer protections in the Affordable Care Act. I support the health care reform law and I am proud of the benefits that this law gives to Americans.

The Marylanders I hear from every day tell me this law helps them and their families. Health care reform saves lives and saves money. It puts more dollars in families' pockets and not into insurance company's profits.

While this law is not perfect, it gets a lot of things right. It ends gender discrimination so that a woman isn't charged 30 to 40 percent more in health insurance premiums simply for being a woman. It holds insurance companies accountable for spending money on quality health care instead of padding their bottom lines. Companies must now spend at least 80 percent of premiums on health care services such as mammograms and prescription drugs.

Insurance companies can no longer deny insurance coverage because someone has a preexisting condition like asthma. In eight States, being a victim of domestic violence was considered a preexisting condition. This law puts a stop to that. Insurance companies can no longer abuse women after they have been abused by their husbands.

Moms and Dads can breathe a sigh of relief because their child, who has leukemia, can no longer be denied health insurance coverage based on a preexisting condition. Additionally, insurers can no longer place a cap on lifetime limits and say it costs too much to treat a child with cancer.

Today we are going to hear from Americans who are benefiting from the health reform law. We will hear how Lisa Grasshoff's son, who has von Willebrand's disease, will no longer have to worry about exceeding lifetime limits. Lisa's insurer must now pay for her son's hemophilia care instead of denying coverage when her family hits the lifetime limit, which can happen pretty fast when you get really sick.

I have also heard from parents in my own State of Maryland, like a woman who wrote to me named Maryanne. She has kids who are 22 and 24 years old. The Affordable Care Act lets children and young adults stay on their parents' health insurance until they are 26. Without these protections, people like Maryanne's kids would be without health insurance. Health care reform reduces the fear families have about providing medical care to their loved ones. Maryanne told me "It's taken America too long to finally do something about health care reform. Please do not allow it to become undone."

I am proud of what we accomplished in health reform. Health care reform saves and strengthens Medicare. It ends the punitive practices of insurance companies. It provides universal access to health insurance. I am particularly proud that this law will also improve the quality of our health care and that we made significant investments in preventive care and public health.

I thank the witnesses for being here today and look forward to hearing from all of them.

RESPONSES TO QUESTIONS OF SENATOR ENZI, SENATOR ALEXANDER,
SENATOR ROBERTS AND SENATOR HATCH BY SECRETARY SEBELIUS

SENATOR ENZI

OVERSIGHT

Question 1. Congress has an obligation to conduct oversight of Federal agencies, to ensure there is transparency in our government and that Federal dollars are used as Congress intended. In order to fulfill this duty, my office and other congressional offices have written a number of letters to you asking for information on issues regarding health care reform implementation and other issues of importance at your agency. The answers we have received, however, are often very late and they rarely adequately address the issue in question.

For example, a letter from 30 Senators asking about your plans for setting up high-risk pools was sent last year on June 22, yet we did not receive a response until September 22d—a full 85 days beyond the date a response was requested. In nearly every other case, HHS was late in responding or in some instances may have ignored the request.

We need to have a better flow of information and better response rate from the Department. During your confirmation hearing in 2009, I believe you personally committed to being responsive to Senators from both parties. What do you plan on doing to ensure that HHS is responding to congressional requests in a more accurate, thorough and timely manner?

Listed below are information requests that HHS either has not answered, or provided an incomplete response. When can I expect a response to the outstanding letters and who on your staff will be responsible for meeting that commitment so that my staff can speak to them?

Date Sent	Letter Description	Deadline	Status
1/11/2010	The committee sent a letter to Secretary Sebelius regarding the failure to disclose a \$400,000 contract with HHS consultant and MIT Professor Dr. Gruber. Dr. Gruber has been one of the Administration's foremost sources of economic analysis in support of their health care proposals.	19-Jan-10	Incomplete response received 156 days past date requested.
3/26/2010	The committee sent a letter requesting information relating to non-confirmed appointees serving under the HELP Committee's jurisdiction. Information requested includes a list of consultants hired since Jan. 20, 2009, a list of all non-career Senior Executive Service (SES) and Schedule C appointees, and quarterly updates.	8-Apr-10	No response; currently 307 days past date requested (As of February 9, 2011).
4/22/2010	Senators Enzi, Burr and Coburn sent a letter to Secretary Sebelius requesting information on what HHS is doing to address the AIDS Drug Assistance Program (ADAP) waiting lists, if statutory authority is needed to provide greater flexibility, and whether remaining stimulus funds will be used to help minimize ADAP waiting lists.	14-May-10	Insufficient response received 53 days past date requested.
4/26/2010	An oversight letter was sent to HRSA, which administers the Ryan White program, to express concern over a February 2010 regulation that rescinded the 24 month cap on emergency housing assistance. The letter requested documentation on the Administration's reasoning for rescinding the program cap as well as information detailing the amount of funding awarded for emergency housing between 2000 and 2009.	15-May-10	Insufficient response received 69 days past date requested.

Date Sent	Letter Description	Deadline	Status
5/27/2010	A letter was sent to Secretary Sebelius relating to the mailer sent by the Centers for Medicare and Medicaid Services to 40 million seniors touting the benefits of health care reform. The letter requests more information on who reviewed the new mailer as well as its cost to taxpayers.	11-Jun-10	Response received 28 days past date requested.
6/22/2010	Senator Enzi and 30 other GOP Senators sent a letter to Secretary Sebelius asking about how the funding for the high risk pool program will work, and what will happen when it runs out.	30-Jun-10	Incomplete response received 85 days past date requested.
7/22/2010	Senators Enzi and Grassley sent a letter to Secretary Sebelius asking for an analysis of the Administration's claim that certain health insurance reforms would lead to a cumulative increase in health insurance premiums of likely less than 1 percent. The letter requests actuarial studies conducted by HHS and poses several questions about the reasoning and methodology they used to arrive at their estimate.	6-Aug-10	Response received 49 days past date requested.
7/29/2010	Senator Enzi and other HELP Republicans sent a letter requesting information about the \$25 million reallocation of funds for Ryan White ADAP waiting lists.	16-Aug-10	Response received 85 days past date requested.
7/29/2010	An oversight letter was sent to Secretary Sebelius requesting information on HRSA's ability to effectively oversee programs under its jurisdiction and the additional \$250 million of funding received under the new health care reform law. There are allegations that 25 percent of all HRSA program grantees are on restrictive draw down plans.	12-Aug-10	Response received 95 days past date requested.

Answer 1. I take Congressional oversight very seriously and it is key to informed policymaking by the legislative branch. I have directed my staff to be forthcoming and as helpful as possible to Congress. I have stressed that we need to be prompt and timely in our responses, but we do want to make sure that we provide you with accurate information. Sometimes that process can require additional time and effort on the part of our staff. As far as I am aware, we have provided you with accurate and complete information. However, I will take a look at the requests you have identified and make sure that we have followed up appropriately.

JOBS

Question 2. In your testimony, you noted that the new law is strengthening the economy. Please specifically identify what new jobs you believe the new health care law has created?

Answer 2. The Affordable Care Act includes tax credits to help make health care affordable for working families. Small businesses can begin claiming tax credits to help provide insurance to their employees this year. All told, the Affordable Care Act includes the largest middle-class tax cut for health care in American history. The law lowers costs for American businesses—especially small businesses—who are struggling to remain profitable and competitive under the status quo. The independent Congressional Budget Office confirmed that the law would lower health insurance premiums by up to 2 percent for small businesses and 3 percent for large businesses, and the Business Roundtable estimated that provisions to help bend the health care cost curve like those in the law could save \$3,000 per person in health costs by 2019. Additionally, independent experts predict that the new law will create jobs—estimated at more than 250,000 per year.

Question 3. In recent testimony before the House Budget Committee, CBO Director Elmendorf indicated that CBO estimates that the new health care law will reduce the number of full-time workers by 800,000 by the time the law is fully implemented. Do you disagree with the CBO analysis, and if so, what data do you possess that supports this belief?

Answer 3. The CBO report says,

“The Congressional Budget Office (CBO) estimates that the legislation, on net, will reduce the amount of labor used in the economy by a small amount—roughly half a percent—primarily by reducing the amount of labor that workers choose to supply. That net effect reflects changes in incentives in the labor market that operate in both directions: Some provisions of the legislation will discourage people from working more hours or entering the workforce, and other provisions will encourage them to work more. Moreover, many people will be unaffected by those provisions and will face the same incentives regarding work as they do under current law.”

Question 4. Has the Department or the Office of Management and Budget calculated how many agents and brokers will likely lose their jobs as a result of the new insurance regulations proposed by your department?

Answer 4. None of the Affordable Care Act regulations take away Americans’ ability to continue to buy coverage through an agent or broker. The medical loss ratio (MLR) rule, however, does ensure consumers are receiving value for their premiums by requiring insurance companies offering coverage in the individual market to spend at least 80 cents of every dollar on medical claims and quality improvement activities, not on administrative expenses like overhead and salaries. Insurers also have to report how much of their premium dollars are spent on agent and broker commissions. Separating broker fees and insurance premiums enables consumers to see exactly what percentage of their premiums is going toward their health care, and protects them from being charged higher premiums to cover an excessive share of non-health care expenses.

Question 5. According to the Congressional Budget Office, “Requiring employers to offer health insurance—or pay a fee if they do not—is likely to reduce employment.” Do you dispute the validity of this analysis? How do you believe employers will respond to the \$52 billion in new taxes on employers imposed by the new health care law?

Answer 5. The Affordable Care Act makes American businesses more competitive by reforming our broken health care system, taking steps to control health care costs, and helping to eliminate the “hidden tax” that drives up the price of employer-based health insurance to cover the cost of care for the uninsured. The law also ensures that Americans who work for employers that do not offer coverage still have access to affordable, high-quality health insurance. In fact the Congressional Budget Office emphasizes that the Affordable Care Act will “encourage other workers to take jobs that better match their skills, because they would not have to stay in less desirable jobs solely to maintain their health insurance.” Further, independent experts predict that the new law will create jobs—estimated at more than 250,000 per year.

COSTS

Question 6. In your testimony, you estimate that a family of four earning \$55,000 a year will save nearly \$6,000 each year as a result of the tax credits. What percentage of Americans will actually be eligible for these tax credits?

Answer 6. The Congressional Budget Office estimates that in 2019, 19 million Americans will receive tax credits to purchase coverage in the Exchanges.

Question 7. Your testimony suggested the medical loss ratio regulation will increase value for consumers. But most consumers are more concerned about health care costs. Do you have any independent empirical analysis that demonstrates that the medical loss ratio regulation will lower costs?

Answer 7. The MLR regulation is designed to ensure that consumers are getting value for their health care dollar. The regulation was issued late last year, but we are already seeing indications that this provision, in conjunction with the Affordable Care Act’s rate review provision, is causing insurance companies to think twice about their premium increases and, in some cases, reducing the size of their annual premium increases. For example, for the second time in a year we have seen insurers in California reduce or delay planned rate increases.

Question 8. Please identify any independent empirical analysis that you are aware of that demonstrates that the rate review regulation will lower health care costs?

Answer 8. Disclosing proposed rate increases, along with the insurer’s justification, will shed light on industry pricing practices that some experts believe have led to unnecessarily high prices. This unprecedented new transparency in the health insurance market will promote competition, encourage insurers to do more to control

health care costs and discourage insurers from charging rates which are unjustified. Importantly, we know rate review works. For example, Connecticut regulators recently rejected a proposed 20 percent rate increase after their review found that such an increase would be excessive.

CONSEQUENCES OF THE NEW LAW

Question 9. In the preexisting condition exclusion interim final rule, the Administration notes:

“There are two main categories of children who are most likely to be directly affected by these interim final regulations: First, children who have a preexisting condition and who are uninsured; second, children who are covered by individual insurance with a rider excluding coverage for a preexisting condition or a preexisting condition exclusion period. For the latter category, obtaining coverage for the preexisting condition may require terminating the child’s existing policy and beginning a new one.”

The regulation also estimates there are 90,000 children in the latter category.

Of these 90,000 children the Department estimates will benefit from the new law, how many live in 1 of the 20 States in which there are no carriers selling new child only health plans? How can parents of these children consider terminating the child’s existing policy if they live in 1 of the 20 States in which there are no new child-only policies available?

Answer 9. In March 2010, the insurance industry said they wanted to make discriminating against children with preexisting conditions a thing of the past. Several months later, they reneged on their commitment and unfortunately, some insurance companies made the unfortunate decision to stop selling child-only insurance policies. We stand ready to work with States and private insurers to facilitate their ability to offer child-only health care policies. Already we have offered to work with States and private plans to have special open seasons and have advised them of other options available to limit adverse selection, such as adjusting rates for health status or permitting child-only rates to be different from rates for dependent children, consistent with State law. We hope that insurers in the affected States will examine all of the flexibility available to them to continue to offer child-only policies and reconsider their decision not to offer child-only policies.

Additionally, CCIIO will continue its work to ensure that Preexisting Condition Insurance Plans (PCIPs) in all States offer viable coverage for children. The PCIP program includes coverage of pediatric benefits, prescription drugs, and inpatient, outpatient, and mental health services. In States where the Federal Government runs the PCIP program, one way uninsured children with preexisting conditions can qualify for PCIP is if they are offered a commercial insurance policy at a premium at least twice as expensive as what they would pay in PCIP in lieu of a denial of coverage by an insurer.

Question 10. In your testimony, you mention 5,000 unions, local governments, and businesses have signed up for the early retiree reinsurance program. Please provide a detailed accounting of who these entities are, which have filed claims, how many claims have been paid and how much of the original \$5 billion allocated for the program has already been spent?

Answer 10. HHS has administered the Early Retiree Reinsurance Program (ERRP) with a great deal of transparency, and all of this information is publicly available on our Web site. On March 31, we published a report announcing that the program has provided more than 1,300 employers across all 50 States with nearly \$1.8 billion in reimbursements. The report details reimbursements received by each participating plan sponsor, and is available here: http://cciio.cms.gov/resources/files/errp_progress_report_3_31_11.pdf.

A March 2, 2010 report providing additional information can be found here: <http://www.healthcare.gov/center/reports/retirement03022011a.pdf>.

In addition, the ERRP page of www.healthcare.gov contains a searchable list of approved plan sponsors by State. The page is directly linked here: <http://www.healthcare.gov/law/provisions/retirement>.

Question 11. Please provide the most recently collected enrollment data by State for the new high-risk pool program authorized in PPACA, including the 23 States in which the Federal Government has contracted with the Government Employees Health Association (GEHA) to run the program.

Answer 11. Based on data reported as of February 1, 2011, PCIP had 12,437 members. Of these, 8,762 were enrolled in State-run PCIPs and 3,675 were enrolled in the federally run PCIP.¹

Question 12. Please provide a detailed accounting of how the Department has spent the \$5 billion allocated for the new high-risk pool program, separately identifying the amounts provided to each State and the funds spent on advertising.

Answer 12. This is still being determined.

Question 13. How many entities have applied for waivers from the annual benefit limit requirement? How many of the applications were accepted by HHS? How many of the applications were denied by HHS? Please also provide a list of all of the names of the entities that have applied for waivers and the current status of their applications.

Answer 13. As of April 1, 2011 a total of 1,168 annual limit waiver applications had been granted. As of February 19, 2011, 79 applicants were initially denied. Applicants that were denied a waiver were informed of their ability to seek a reconsideration of CCIIO's determination. Some applicants that have asked for reconsideration have been subsequently approved. An updated list of approved applications by plan type can be found on CCIIO's Web site here: http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html.

Question 14. Please describe the process that the Department has used to determine whether to grant a waiver from the annual benefit limit requirement. As part of this answer, please identify the criteria that are used to assess the merits of the request, as well as the policies and procedures that are used by your staff to make waiver determinations. Please identify which individuals within the Department are responsible for making these determinations, the role the HHS General Counsel in reviewing these decisions, and any processes that are being used to ensure that the waivers are issued in a manner that is consistent with the policies and procedures described above.

Answer 14. Information on the waiver process is available in our guidance, here: http://cciio.cms.gov/resources/files/ociio_2010-1_20100903_508.pdf.

Question 15. Have any entities or health plans been issued waivers exempting them from any requirements included in PPACA (other than the waivers that have been issued exempting plans from meeting the annual benefit limits)? Does HHS intend to issue waivers exempting any entities from any other requirements included in PPACA?

Answer 15. As you note, as of April 1, 2011, 1,168 group health plans or health insurance issuers had received 1-year waivers from the restricted annual limits provision, consistent with the Secretary's responsibilities under the statute.

The Affordable Care Act permits an adjustment to the Medical Loss Ratio (MLR) standard for a State's individual health insurance market for up to 3 years if it is determined that applying the 80 percent MLR standard "may destabilize the individual market in such State." In order to qualify for this adjustment, a State must demonstrate that requiring insurers in its individual market to meet the 80 percent MLR has a reasonable likelihood of destabilizing the State's individual insurance market and could result in fewer choices for consumers. Under this standard, HHS accepted the Maine Bureau of Insurance request for an adjustment to 65 percent for 2011 and 2012. HHS will allow the adjustment to continue through 2013, as Maine requested, if the State provides additional data at the end of 2012 to support a third year of the adjustment to 65 percent.

PREVENTION FUND

Question 16. The new health care law established a Prevention and Public Health Fund (PPHF), which will provide \$15 billion over the next 10 years for prevention, wellness and public health activities. Recent HHS press releases indicated that \$500 million was allocated from this fund last year for these activities and \$750 million will be spent this year.

Please provide a detailed accounting of how these funds have been spent. As part of your answer, please provide the names of all entities that have received funds, the amounts they received, the stated purpose for which the funds are to be used and the agencies within HHS that actually dispersed the funds.

Answer 16. Attached please find spreadsheets that display a detailed accounting of how HHS obligated the \$500 million from the FY 2010 Prevention and Public

¹[Note: We should have updated numbers soon.]

Health Fund (PPHF). The financial information displayed represents the most current available as of March 2011. The attached spreadsheets are organized based upon the agencies that awarded the funds²:

- HRSA: 1 summary spreadsheet, 5 program-specific spreadsheets showing obligations of PPHF funds.
- CDC: 1 spreadsheet showing obligations for PPHF-funded programs by grant mechanism (data pulled between 12–1–2010 and 2–9–2011), 1 spreadsheet that describes the program funded by each grant mechanism.
- OS: 2 spreadsheets—1 displays ASPA and ASPE programs, 1 displays OASH programs funded with the PPHF.
- SAMHSA: 1 spreadsheet showing all awards under the Primary and Behavioral Health Integration program.
- AHRQ: 1 spreadsheet showing PPHF funds obligated for the U.S. Preventive Services Task Force and Healthy Weight Practice-Based Research Networks.

As of March 23, 2011, HHS has not obligated any of the proposed \$750 million from the *FY 2011* Prevention and Public Health Fund.

Question 17. Please describe the process that the Department has used to determine the eligibility of an entity to receive funds from the PPHF. As part of this answer, please identify the criteria that are used to assess applications, the policies and procedures used to determine eligibility and the amount of funding to be provided to an entity, and whether the process used to make determinations was a competitive one. Please also identify. Please identify which individuals within the Department are responsible for making these determinations, how input from stakeholders is collected and used in this process, the role the HHS General Counsel in reviewing these determinations, and any processes that are being used to ensure that all determinations are made in a manner that is consistent with the policies and procedures described above.

Answer 17. The Affordable Care Act states that the purpose of the Prevention and Public Health Fund is for an “expanded and sustained national investment in prevention and public health programs that will improve health and help restrain the rate of growth in private and public sector health care costs.” The resources from the Fund serve as a funding source for many existing HHS programs and new programs that meet this purpose, and the Fund does not have its own eligibility criteria. Generally, across the range of HHS programs funded with Prevention and Public Health Fund resources, grants supported by the Fund are available to universities, States and local governments, professional health organizations, tribal organizations, community and faith-based organizations.

Each agency’s program has its own eligibility requirements, and the funding opportunity announcements (FOAs) for each program, which are posted on the respective operating division’s Web site and on grants.gov, describe in full detail the purpose of the award, eligibility requirements, estimated award amount(s), application deadline, and method of selection. As with other HHS grant programs, applications that meet the eligibility requirements and are responsive to the FOA are reviewed and scored by an objective review panel based on the criteria published in the FOA. The review panels are comprised of experts knowledgeable in the relevant field. Applications for awards that support research are reviewed for both scientific merit and programmatic conformance. Awards are made according to rank score, additional published criteria, if any, and the availability of funds. After all selections have been made, organizations whose applications were reviewed but not funded will be notified of their status. An application will remain active for 1 year from the date of notification.

HHS General Counsel reviews all funding opportunity announcements related to programs supported by the Prevention and Public Health Fund and ensures that all awardee determinations comply with standard HHS policies and procedures as well as the laws governing grant authority.

Question 18. As you prepare to spend the \$750 million allocated for distribution this year, please identify the criteria that will be used to determine the most effective prevention and public health activities to fund, how funding will be distributed among prevention and public health activities, and whether geographic and demographic characteristics were used to determine program funding.

Answer 18. The Prevention and Public Health Fund offers HHS the opportunity to fund the best evidence-based interventions. The Affordable Care Act authorizes the award of funds to programs that provide for an expanded and sustained national

²[Note: These charts may be found in the attached pdf documents].

investment in prevention and public health improvement. We have engaged in a constructive dialogue within the Administration and Congress on specific, high-impact investments that can make a difference in the health of Americans. By investing in State and local public health infrastructure and community efforts to implement proven prevention programs, we can make a significant impact on the leading causes of death.

Because of the Prevention and Public Health Fund, businesses, schools and other educational institutions, State and local governments, and non-profits have received the much-needed financial investment for programs such as tobacco cessation, obesity prevention, and increasing the primary care and public health workforce. In several cases, geographic and/or demographic characteristics were used to determine program funding based on population size, burden of disease, and ability to reduce health disparities and/or achieve positive health outcomes.

For fiscal year 2011, building on the initial investment of fiscal year 2010, new funds are dedicated to expanding on four critical priorities:

1. Community Prevention (\$298 million): The initiative supports community prevention activities that we know will work to reduce health care costs and promote health and wellness.

- Community and State Prevention (\$222 million). Implement the Community Transformation Grant program and strengthen other programs to support State and community initiatives to use evidence-based interventions to prevent heart attacks, strokes, cancer and other conditions by reducing tobacco use, preventing obesity, and reducing health disparities. Launch a consolidated chronic disease prevention grant program.
- Tobacco Prevention (\$60 million). Implement anti-tobacco media campaigns which are proven to work to reduce tobacco use, telephone-based tobacco cessation services, and outreach programs targeting vulnerable populations, consistent with HHS' Tobacco Control Strategic Action Plan.
- Obesity Prevention and Fitness (\$16 million). Advance activities to improve nutrition and increase physical activity to promote healthy lifestyles and reduce obesity-related conditions and costs. These activities will support the First Lady's "Let's Move!" initiative and help implement recommendations of the President's Childhood Obesity Task Force.

2. Clinical Prevention (\$182 million): The initiative supports clinical preventive services that we know will work to reduce health care costs and promote health and wellness.

- Access to Critical Wellness and Preventive Health Services (\$112 million). Increase awareness of new preventive benefits made available by the Affordable Care Act. Expand immunization services and activities. Strengthen employer participation in wellness programs.
- Behavioral Health Screening and Integration with Primary Health (\$70 million). Assist communities with the coordination and integration of primary care services into publicly funded community mental health and other community-based behavioral health settings. Expand suicide prevention activities and screenings for substance use disorders.

3. Public Health Infrastructure and Training (\$137 million): The allocation strengthens State and local capacity to prepare health departments to meet 21st century challenges.

- Public Health Infrastructure (\$40 million). Support State, local, and tribal public health infrastructure to advance health promotion and disease prevention through improved information technology, workforce training, and policy development.
- Public Health Workforce (\$45 million). Support training of public health providers to advance preventive medicine, health promotion and disease prevention, epidemiology, and improve the access to and quality of health services in medically underserved communities.
- Public Health Capacity (\$52 million). Build State and local capacity to prevent, detect, and respond to infectious disease outbreaks through improved epidemiology and laboratory capacity. Increase investments in programs that prevent healthcare associated infections.

4. Research and Tracking (\$133 million): The initiative supports the Affordable Care Act's expansion of coverage for community and clinical preventive services by increasing resources for research and evaluation of preventive services.

- Health Care Surveillance and Planning (\$84 million). Fund data collection and analysis to monitor the impact of the Affordable Care Act on the health

of Americans. Boost the collection and analysis of environmental hazards data to protect the health of communities.

- Prevention Research (\$49 million). Strengthen the CDC-facilitated Community Guide by supporting the Task Force on Community Preventive Services' efforts to identify and disseminate evidence-based recommendations on important public health challenges to inform practitioners, educators, and other decisionmakers. Expand the development of recommendations for clinical preventive services, with enhanced transparency and public involvement in the processes of the U.S. Preventive Services Task Force. Fund cross cutting public health research studies.

Question 19. Please describe how, on an ongoing basis, the Department will inform the public and Congress about how the PPHF funds are used.

Answer 19. Information will be publicly available on an ongoing basis which will detail how the PPHF funds are used. As is our usual practice, as grants are awarded, HHS will relay that information via press releases and fact sheets on the various agencies' Web sites, www.hhs.gov and/or www.healthcare.gov. Information regarding the State-by-State breakdown of the fiscal year 2010 PPHF funds is already available on the Web site as is information regarding the categories of fiscal year 2011 PPHF dollars. For more information, visit <http://www.healthcare.gov/news/factsheets/prevention02092011a.html> and <http://www.healthcare.gov/news/factsheets/prevention02092011b.html>.

Interested parties may also contact Grants Management Specialists in the various Operating Divisions to formally request this information. In addition, there are useful Web sites that provide additional information. For example, the Computer Retrieval of Information on Scientific Projects (CRISP) (<http://crisp.cit.nih.gov>) is a public Web site that shows funded grants from CDC's IMPAC II grants management system.

Question 20. Please describe how the Department will measure the efficacy of the programs funded under Section 4002, specifically with regard to improving the health outcomes of specific individuals and reducing health care expenditures.

Answer 20. Recipients of grants funded with Prevention and Public Health Fund resources are expected to achieve the stated outcomes of the grant. Awardees will develop evaluation plans to ensure performance monitoring and tracking of overall progress on outcome objectives as well as specific progress on activities designed to address the core objectives of the respective program. In addition, PPHF resources are available for healthcare surveillance and statistics activities, which will track the impact of the ACA, such as changes in the health care system and local, State, and national trends over time. HHS plans to use measures such as: percentage of adults who smoke cigarettes, percentage of adults with a healthy weight, percentage of children with a healthy weight, percentage of infants born at a low-birth weight, percentage of people receiving seasonal influenza vaccine in the last 12 months, and percentage of people who have a specific source of ongoing medical care, among others.

COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS ACT (CLASS ACT)

Question 21. The CLASS Act was passed as part of the Patient Protection and Affordable Care Act of 2010. On January 5, you sent a letter to Congress stating that the CLASS Act programs would be moved to the Administration on Aging (AOA). The following questions concern that move and the overall implementation of the CLASS Act.

Is the Administration on Aging (AOA) receiving funds to administer the program? Are Federal funds being transferred from other previously appropriated programs, such as Own Your Future and the National Long-Term Care Clearinghouse, to finance the administrative costs of the CLASS Act? Please list any programs whose funding has been shifted to implement the CLASS Act, and for each fiscal year. Please specify whether these are mandatory or discretionary funds. Please also list the statutory authority for the use of these funds for the implementation of the CLASS Act.

Answer 21. The President's fiscal year 2012 Budget requests \$120 million in administrative funding for the CLASS program, including significant investments for the development of a national IT system and education and outreach to potential participants and employers. The requested funds will be used to bridge the period between fiscal year 2011 when funding is covered under the Health Reform Implementation Fund authorized by Section 1005 of P.L. 111-152 and the point at which administrative funding can be drawn statutorily from premiums received.

For fiscal year 2010 and fiscal year 2011, no AOA funding is being used to administer CLASS. The program's expenses are being funded entirely by the Health Reform Implementation Fund. No funding has been transferred from other programs.

Question 22. Is there expected to be an advertising and/or outreach campaign for the CLASS Act programs? If so, what is the 10-year budget for the advertising/outreach campaigns? How will the monies be spent? Where will the Department of Health and Human Services (HHS) find the money for the campaign? Please specify whether these are mandatory or discretionary funds. Please also list the statutory authority for the use of these funds for the implementation of the CLASS Act.

Answer 22. The CLASS Act is designed to help Americans prepare for their financial future by offering insurance that will help pay for an individual's future long-term care needs. The CLASS program is required by law to maintain solvency over 20 and 75 years. The Department of Health and Human Services (HHS) will ensure CLASS meets these statutory requirements, and no taxpayer funds will be used for payment of benefits. Outreach and education will be crucial components of achieving the goals of the CLASS program for two reasons. First, surveys show widespread misunderstanding about the nature of long-term care costs and the extent to which Medicare pays for these services and supports. Outreach and education will provide Americans with information they need to plan responsibly for their own future. Second, an informed public is more likely to recognize the benefits that CLASS provides and choose to participate in the program, boosting participation and improving the fiscal solvency of the program.

The President's fiscal year 2012 Budget requests \$120 million in discretionary appropriations to fund outreach, education and administration. This funding will be spent pursuant to Title 32 of the Public Health Service Act.

Question 23. Recently, I was informed that HHS intends to contract with outside groups, Knowledge Networks and Thompson Reuters, to conduct a study and surveys on who is purchasing long-term care insurance and related products. Were these contracts put out for competitive bid? Will you please supply copies of the contracts?

Answer 23. The Department of Health and Human Services (HHS) will develop CLASS to meet the program's statutory requirements for solvency over 20 and 75 years, and no taxpayer funds will be used for the payment of benefits. HHS is conducting research to increase our understanding of Americans' attitudes, opinions and knowledge of the risks of needing long-term care and their likely need for services. The information will be used to support development of the CLASS benefit. The contracts to Thompson Reuters and Knowledge Networks were awarded pursuant to Federal Acquisition Regulations. The Thompson Reuters contract was awarded through the Department's competitive indefinite delivery/indefinite quantity (ID/IQ) task order contract mechanism. The contract to Knowledge Networks was awarded through the GSA Mission Oriented Business Integrated Services (MOBIS) Schedule (Survey Services 874-3). Copies of these contracts are attached.

Question 24. If surveys were used by these outside groups on behalf of a study undertaken for HHS, Federal law requires that the surveys of more than 10 individuals must be approved by the Office of Management and Budget. Please supply copies of the OMB approval of these surveys and copies of all surveys used.

Answer 24. All surveys that will be conducted to support CLASS program development will undergo review by OMB, as required under the Paperwork Reduction Act (PRA). All information collection requests (ICRs) submitted by agencies for OMB approval under the PRA can be found at <http://www.reginfo.gov/public/do/PRASearch>. OMB has reviewed and approved one survey that contained questions related to the CLASS Act. These questions added to HHS/CDC's National Health Interview Survey (approved by OMB on December 13, 2010) can be found at: http://www.reginfo.gov/public/do/PRAViewDocument?ref_nbr=201009-0920-002.

Question 25. In adhering to the President's commitment to transparency and abiding by government contract regulations, please list all studies that have been submitted to OMB for approval in the last 180 days. Include the estimated cost of the study, the source of the funding, as well as the organization in charge of its administration.

Answer 25. No studies have been submitted to OMB for approval.

Question 26. The SCAN Foundation has actively advocated for passage of the CLASS Act and has awarded grants to help implement the program. In fulfilling Congress' obligation to conduct routine oversight please describe the Department's and AOA's relationship and communication with the Foundation. Does AOA receive

any funding or resources from the SCAN Foundation? If so, please provide a breakdown for each fiscal year. Is SCAN or any of its employees or representatives currently under contract or serve as a consultant to HHS?

Answer 26. The SCAN Foundation operates independently and does not fund any HHS activities. HHS officials and staff meet with representatives from a range of outside organizations on numerous aging and long-term care issues; SCAN is among those organizations. No employees of the SCAN Foundation are under contract with or serve as a consultant to HHS related to the CLASS Act.

Question 27. Has the Department or AOA hired any staff for the purposes of running the CLASS Act programs? Please list any employees or contractors hired for purposes of the CLASS Act and their roles in implementing the CLASS Act. How many full-time employees does HHS or AOA anticipate hiring for the implementation of the CLASS Act programs? Will employees of other Federal agencies be used for the implementation of the CLASS Act programs?

Answer 27. Yes, currently the CLASS program has a team of 12 full-time staff. The staff includes program specialists and IT professionals. The fiscal year 2012 budget request discusses the Administration on Aging's plans to have approximately 22 full-time equivalents or FTEs working on the CLASS program in fiscal year 2011. The fiscal year 2012 budget requests an appropriation to support 40 FTEs in fiscal year 2012.

Question 28. Has the Department of AOA hired an actuary for the CLASS Act? Pursuant to Section 3203 of the CLASS Act, you shall develop at least three actuarially sound benefit plans as alternatives for the CLASS Independence Benefit Plan. Have you consulted with the three actuaries, and if so, who are the actuaries? Is the actuary for the Centers of Medicare and Medicaid Services (CMS) one of the three actuaries? When will the three alternatives be shared with Congressional Oversight Committees? When will the final decision be made with respect to which actuarial plan alternative will be the basis for the CLASS Act implementation? Will you require that each of the actuarial analyses contain a 75-year analysis?

Answer 28. Yes. AOA/CLASS has hired an actuary, Robert Yee, who has over 30 years of actuarial and executive experience, including at the largest provider of private long-term care insurance in the country. Robust actuarial estimates will be crucial components of achieving the goals of the CLASS program. The statute requires the development of three benefit plans. The methods and assumptions that underlie these plans must be certified by the CMS Actuary.

Question 29. What discussions have taken place between HHS/AOA and the Department of Treasury regarding the establishment of enrollment mechanisms for collecting CLASS Act program premiums?

Answer 29. We have had conversations with the Department of Treasury for advice on how to establish IT systems for accurate and streamlined collection of premiums. The CLASS program is working on mechanisms for employers and individuals to pay premiums into the program, including through third-party payroll processors.

Question 30. What discussions have taken place with States and related entities and the private sector in the establishment of the eligibility assessments pursuant to Section 3205 of the CLASS Act?

Answer 30. We have not discussed CLASS eligibility assessment issues with States. However, we are conducting research on eligibility assessments currently used in the private long-term care insurance market, and examining closely the assessment procedures used by State insurance and Medicaid programs.

Question 31. When will the first premiums be collected pursuant to the CLASS Act programs? Will the collection of premiums begin prior to the establishment of the CLASS Independence Benefit Plan? Will the collection of premiums begin prior to the establishment of enrollment mechanisms for all entities and individuals? What regulations need to be finalized before premiums collection commences?

Answer 31. The Department will announce the CLASS plan by October 2012, after considering the recommendation of the CLASS Independence Advisory Council. Enrollment and premium collection will not begin until a benefit plan, enrollment mechanisms, and information systems are established.

Question 32. Recently, you gave a speech to the Kaiser Family Foundation concerning the CLASS Act. You claimed that the CLASS Act has loopholes and that it only offers two options for setting premiums and "[n]either of these options is appealing." What loopholes need to be fixed? Will these require legislative changes?

What other options are you considering for premiums? Will these premium issues require legislative changes?

Answer 32. We are not seeking legislative changes. As I said in my speech at the Kaiser Family Foundation, we are taking advantage of the flexibility allowed us in the statute to structure premiums in order to keep CLASS solvent.

For example, I will use the flexibility the law allows to ensure that there are not loopholes in the law that allow people to enroll in the program and then strategically skip payments yet remain enrolled.

Question 33. In recent years, the Federal Government's own long-term care insurance programs experienced a serious spike in cost of premiums to those enrolling in the program. How can you ensure that no premium spikes will occur with those enrolling in CLASS Act programs? Will enrollees in CLASS Act programs be given the opportunity to receive a refund if premium spikes are too high?

Answer 33. We are looking at options for indexing premiums so that they will rise along with benefits. The indexing system would have to be completely transparent. That way people can plan ahead without being surprised by sudden large rate increases.

GENERAL

Question 34. States are having a difficult time balancing their budgets due to restrictive Medicaid maintenance of effort (MOE) requirements. You recently recommended different strategies for States, such as purchasing drugs more efficiently, but many of these strategies have already been employed by States over the past few years to rein in spending.

How are States supposed to implement new and innovative approaches in the short term AND long term when they are heavily restricted by the current MOE requirements?

Answer 34. As a former Governor, I know the difficult budget pressures facing States. The Administration has a strong track record on our partnership with States during difficult economic times. Working with Congress, we increased Federal support for Medicaid, supporting increased enrollment at the same time when State Medicaid resources were down. Working again with Congress, we extended the Children's Health Insurance Program (CHIP) to secure funding into the future. As a result, in 2009, even though Medicaid enrollment rose because of the recession, State spending in Medicaid declined by 10 percent.

There are a number of steps States can take to reduce costs and squeeze waste, fraud and abuse from their programs. On February 3, 2011, I sent a letter to all Governors laying out a broad array of options already available to them to reduce their spending and balance their budgets, as well as new ideas that can be accomplished through existing options or waivers. States have many choices they can make including limits on some benefits, changes in cost sharing, and greater use of managed care. A copy of the letter can be found at: <http://www.hhs.gov/news/press/2011pres/01/20110203c.html>.

Medicaid cost issues largely reflect the cost issues facing our health care system as a whole. Like other payers, States can save considerable dollars by focusing on improving the safety and quality of care. Efforts to reduce and eliminate unnecessary hospital readmissions are a great example. Preventing one readmission of a disabled adult with Medicaid can save enough money to cover three adults without disabilities for an entire year.

On February 25, 2011, CMS also sent a letter to State Medicaid directors clarifying situations in which the maintenance of effort provision does not apply. (Please visit the CMS Web site for a copy of the letter to States: <http://www.cms.gov/smdl/downloads/SMD11001.pdf>.) CMS intends to continue to work with Governors on further exploring existing flexibility and options to improve Medicaid's performance. CMS recently created the Medicaid State Technical Advisory Teams (M-STAT) that are responsible for working directly with States to address steps they can take to improve efficiency in their programs and develop effective cost containment strategies.

We are also exploring options such as those that will be proposed by the National Governor's Association. We continue to work closely with States on innovative approaches to improve the quality and efficiency of care provided to high-cost beneficiaries, such as those eligible for both Medicare and Medicaid (dual eligibles).

Question 35. Medicare Actuary Richard Foster recently wrote that an additional 5 million or more early retirees may be added to the Medicaid rolls in 2014 if current adjusted gross income definitions are maintained. This represents an increase of 25 percent over initial projections.

How are States expected to respond to these future increases in costs when the Federal Government is already facing a \$14 trillion national debt and major flexibility is not allowed for the States by the Federal Government?

Answer 35. I recognize the challenge that the current fiscal environment has posed for State budgets including the increased enrollment in Medicaid, which is designed to serve more people during downturns, as people lose jobs and their job-based coverage. By providing new Medicaid coverage through the Affordable Care Act, we are reducing the costs and inefficiencies resulting from the lack of insurance that plague our health system, and raise costs for all Americans and businesses in all States.

The Federal Government will pay 100 percent of the Medicaid cost for the first 3 years for newly eligible adults. After that, the Federal Government will pay at least 90 percent of the cost of the expansion. By greatly increasing the number of people with health insurance, the Affordable Care Act will also help States save money on other safety net programs and uncompensated care. Many services that States currently provide for the uninsured and pay for on their own—like mental health care and hospital treatment—will be matched by Federal Medicaid funds.

As Secretary, I am committed to working closely with States to minimize potential financial and administrative burdens of implementing the Affordable Care Act. For example, some States have calculated that overall they will not bear any new costs under the law. CMS recently issued a final rule to provide States with a 90 percent enhanced match on investments in their IT systems for the design and implementation of changes to their Medicaid eligibility systems and we are committed to drive down the overall costs of these investments through shared technology.

Question 36. While implementing \$500 billion in Medicare payment cuts, please identify how the new health care bill will specifically decrease costs for patients as competition decreases and the Federal Government takes a larger role in managing health care in the United States?

Answer 36. The Affordable Care Act contains numerous new provisions that are specifically directed at reducing the cost of care.

For example, the Affordable Care Act supports ambitious new efforts to reduce fraud and waste in the health care system. New authorities in the Affordable Care Act offer additional front-end protections to keep those who commit fraud out of Federal health care programs, as well as new tools for deterring wasteful and fiscally abusive practices, promptly identifying and addressing fraudulent payment issues, and ensuring the integrity of our programs.

Another example is the Center for Medicare and Medicaid Innovation. This new cross-cutting resource for improving care access and coordination for Medicare, Medicaid, and CHIP beneficiaries will test and study the most promising innovative payment and service delivery models. In doing so, the Innovation Center will work collaboratively with relevant Federal agencies and clinical and analytical experts, as well as local, national and regional providers, States and beneficiary organizations to identify and promote systems changes that could improve quality and outcomes for patients while containing or reducing costs.

The Affordable Care Act also established a Federal Coordinated Health Care Office to improve coordination of the care provided to beneficiaries eligible for both Medicare and Medicaid, also known as dual eligibles. This population consists of the most vulnerable and chronically ill beneficiaries, who represent 15 percent of enrollees and 39 percent of Medicaid expenditures and 16 percent of enrollees and 27 percent of Medicare expenditures. These individuals experience many challenges obtaining care under the current system. Dual eligibles need to navigate two separate systems: Medicare for primary coverage of basic health care services (e.g., preventive, primary, acute, and post-acute care) and prescription drugs, and Medicaid for wraparound coverage, including coverage of long-term care supports and services, and help with Medicare premiums and cost-sharing. The Federal Coordinated Health Care Office will work to better streamline care for dual eligibles and partner with States to introduce new integrated care delivery models that ensure they receive full access to the items and services that will result in better health care outcomes and lower overall costs, while reducing duplicative or wasteful care.

Other cost-saving innovations in Medicare and Medicaid include programs to reduce unnecessary hospital readmissions, reduce and eliminate healthcare-acquired conditions, and initiate shifts in our payment systems that, in the long run, will reward quality of care over quantity of care.

Finally, the Affordable Care Act will reduce premiums by an estimated 14–20 percent for Americans who buy health insurance on their own in the new competitive insurance Exchanges. Beginning in 2014, the law will allow individuals, families, and small business owners to pool their purchasing power through new State-based

Exchanges. Millions will qualify for tax credits to help them buy coverage through the Exchanges. Under the new law, it is estimated that a family of four making about \$33,000 could save nearly \$10,000 in premiums, beginning in 2014, if they purchase coverage in the Exchange. A family of four making \$56,000 could save up to \$6,000 each year, by purchasing Exchange coverage. The Affordable Care Act has brought real change to the health insurance marketplace that has immediately benefited thousands of Americans, and will improve coverage and provide real savings for millions more.

Question 37. In December 2010, it was announced that Ohio State University would receive a \$100 million grant for its Radiation Oncology Center, pursuant to a provision in the new health care law. Please identify all of the hospital systems that applied for this grant and the process that was used to determine the winner. Please also identify which individuals within the Department who were responsible for making this determination and describe the role of the HHS General Counsel in reviewing this decision.

Answer 37. Section 10502 of Affordable Care Act provided for a single grant for up to \$100 million for debt services on, or direct construction or renovation of, a health care facility that provides research, inpatient tertiary care, or outpatient clinical services. Eligibility for this award was limited to institutions of higher education with an academic health center at a public research university in the United States that contained the State's sole academic medical and dental school. The funding opportunity was announced August 18, under Announcement Number: HRSA-11-126.

Potential applicants were invited to ask the Agency questions about the program guidance and application requirements. HRSA staff, after consultation with the Office of the General Counsel, responded to questions via email, telephone, and conference calls, with the questions and answers then posted on the HRSA Web site as Frequently Asked Questions for all potential applicants to see.

Eleven applications were received for funding under the Infrastructure to Expand Access to Care funding opportunity announcement, four of which were determined by the Agency as not having met the programmatic eligibility requirements. The remaining seven applications were deemed eligible.

An external Objective Review Committee was established to evaluate the eligible applications. The review committee was staffed with non-Federal persons free of conflicts of interest with expertise in the areas of: health care administration within an institution of higher education; health facility construction and design; and capital finance. After the committee discussed and evaluated each application on its own merit and based on what was in the application alone, each member of the Review Committee independently scored that application. A Federal grants office determined a rank order based on the committee scores. Consistent with HRSA's grant practices, the applicant with the highest score, the Ohio State University, was awarded the grant.

SENATOR ALEXANDER

Question 1. As a former Governor, I am deeply concerned with the Medicaid expansion in the new health law. Tennessee's previous Governor Bredesen, a Democrat, has called it "*the mother of all unfunded mandates*" and estimated that it will cost Tennessee an additional \$1.1 billion for 2014-19, and that is even with the Federal Government paying 100 percent of the expansion population from 2014-16.

The new law also mandates that Medicaid primary care physicians be reimbursed at 100 percent of Medicare rates in 2013-14, for which the Federal Government will pay for those 2 years. But this creates a funding cliff for 2015. To keep doctors in their programs, States will either be forced to continue to pay Medicaid primary care physicians 100 percent of Medicare rates, or these physicians will effectively see a 40-50 percent cut in 2015. According to the TennCare director, the requirement to increase provider reimbursement to 100 percent of Medicare would cost Tennessee roughly an additional \$324 million per year.

How are States going to shoulder these additional burdens in the current budget crises most of them are experiencing? Is the Administration considering any kind of flexibility options to offer to States in order to avoid being crushed by all the mandates and maintenance of effort requirements?

Answer 1. As a former Governor, I know the difficult budget pressures facing States. The Administration has a strong track record on our partnership with States during difficult economic times. Working with Congress, we increased Federal support for Medicaid, supporting increased enrollment at the same time when State Medicaid resources were down. Working again with Congress, we extended the Children's Health Insurance Program (CHIP) to secure funding into the future.

TennCare relies on private managed care companies to provide care to a Medicaid population—a group that often has special needs and higher costs. Just 5 percent of Medicaid beneficiaries account for more than half (55 percent) of all spending. By contrast, 50 percent of beneficiaries—those with the lowest costs—account for only 5 percent of spending. To truly get a handle on growing Medicaid costs and to improve health status overall, we need to help States find ways to better care for these high cost enrollees, people who often have multiple chronic conditions or other special health care needs.

The Affordable Care Act includes a number of provisions to help improve care while lowering costs, such as a Medicaid health home State plan option and new authorities through the Innovation Center that will enable States to design and test new care management and care coordination strategies in both managed care and fee-for-service contexts.

There are a number of steps States can take to reduce costs and squeeze waste, fraud and abuse from their programs. I recently sent a letter to all Governors laying out a broad array of options already available to them to reduce their spending and balance their budgets, as well as new ideas that can be accomplished through existing options or waivers. States have many choices they can make including limits on some benefits, changes in cost sharing, and greater use of managed care. States can also save considerable dollars by focusing on improving the safety and quality of care. I intend to work with Governors on exploring existing flexibility and options.

Question 2. One of the problems with the Medicaid expansion is that there is an access problem for patients in the program being unable to see a doctor willing to treat them. There are varying reports on providers not willing to see Medicaid patients, like the 2006 report from the Center for Studying Health System Change Only stating that about half of U.S. physicians accept new Medicaid patients.

Even the CMS chief actuary stated in an analysis done in April, “. . . it is reasonable to expect that a significant portion of the increased demand for Medicaid would be difficult to meet, particularly over the first few years.”

By adding 16–18 million more people into the program, what is your Administration doing to address access issues for all these new beneficiaries?

Answer 2. As Secretary, I am committed to ensuring access for Medicaid beneficiaries. A good first step is a provision in the Affordable Care Act that provides a federally funded boost in payment rates to primary care physicians for 2 years, which will ensure that such providers have a strong incentive to serve program beneficiaries. The Affordable Care Act also takes important and significant steps to boost the number of primary care providers, including new bonus payments for primary care in Medicare and new residency slot allowances.

In addition, the newly formed Medicaid and CHIP Payment and Access Commission (MACPAC) will also play an important role by providing research and analysis on provider payment rates and access in the Medicaid program. We anticipate working closely with them as we do with MEDPAC.

Question 3. Has HHS done an analysis of how many providers are not seeing new or any Medicaid patients? If not, can your department look into this and get back to me?

Answer 3. Ensuring access to care is a key goal of this Administration, especially as we look ahead to coverage expansions in 2014. In fact, we are currently undertaking rulemaking to help CMS better ensure that Medicaid beneficiaries can access high quality care in a timely manner. We expect to have proposed regulations available for public comment in the spring and would welcome input in this area.

CMS does not currently track rates of provider participation in the Medicaid program. However, in their March 2011 Report to Congress (<http://www.macpac.gov/reports>), the Medicaid and CHIP Payment and Access Commission (MACPAC) provided selected surveys examining provider participation in Medicaid and CHIP that may be informative in understanding current provider participation rates.

Question 4. In your testimony, you mention tax credits as a way that the law will keep down premiums. I realize that people who receive the tax credits or subsidies will pay less out of their own pocket for premiums, but are you saying that these tax credits/subsidies will bring down the underlying premiums and or the underlying cost of health care?

Answer 4. The Congressional Budget Office (CBO) produced estimates of the impact of the Affordable Care Act on premiums, even without the impact of the tax credits. For people purchasing non-group coverage through the Exchanges, it estimated savings of 7 to 10 percent resulting from the increase in the size of the insurance pool as well as the nature of the new enrollees, many of whom, in light of the premium tax credits and the individual responsibility provisions, are likely to be rel-

actively younger, healthier at any given age, and/or have lower expected utilization of health services. An additional 7 to 10 percent savings would result from providing the same set of services to the same group of enrollees—primarily because of the new rules in the market such as eliminating insurance underwriting. CBO also credits some of the savings to increased choices and competition. Together, these savings range from 14 to 20 percent.

Question 5. According to estimates from Senate Finance minority tax staff last year, only 7 percent of Americans would qualify for subsidies and would see these cost savings. What about everyone else? Even CBO has said premiums for families buying coverage on the individual market would see premiums increase by \$2,100 a year. Blue Shield of CA had increases as high as 59 percent—some of that is directly attributable to the new health care law.

Answer 5. The vast majority of Americans who have health insurance get coverage through their employer, and that will not change when the Affordable Care Act is fully implemented. The Congressional Budget Office (CBO) estimates that premiums for small businesses will be up to 2 percent lower and premiums for large business will be up to 3 percent lower because of key reforms in the Affordable Care Act. And longer term reforms in the law will reduce the “hidden tax” that drives up the price of employer-based health insurance to cover the cost of care for the uninsured.

For Americans that purchase insurance in the individual market, Exchanges will bring transparency and fairness to a broken system, and significant tax credits will be available to offset the costs of coverage. Even without factoring in the impact of the tax credits, CBO estimates that the cost of comparable coverage in the Exchange will be 14 to 20 percent lower than they would be without the Affordable Care Act. This translates to savings of an estimated \$2,300 per year for families. CBO also assumed that individuals and families would have, on average, coverage that is more comprehensive than what they have now, meaning that the savings would be offset by higher premiums due to better coverage. It is important to note that this benefit enhancement is largely a choice, not a requirement.

Question 6. You state in your testimony that the new law “is bringing down premiums for consumers by limiting the amount of premiums insurers may spend on administrative costs and by giving States resources to beef up their review process.”

How do you square this statement with recent news articles that some insurers are raising premiums as a result of the new law?

Answer 6. The Affordable Care Act holds insurers accountable and will help bring down premiums. It ensures every significant health insurance rate increase will undergo a thorough review and provides \$250 million in grants to States to bolster their rate review process. For the first time, insurers will be held accountable for the way they spend consumer premiums. The new medical loss ratio regulations released last year implement the statutory requirement that insurers spend at least 80 or 85 percent, depending on the market, of premium dollars on health care and quality improvement efforts instead of marketing and CEO bonuses. Those insurers who don’t meet the standard will have two choices: reduce premiums or send rebates to their customers. There is growing evidence that these provisions are resulting in reductions in premium increases or withdrawal of rate increases.

Question 7. PPACA requires insurers to establish a medical loss ratio (MLR) for 80 percent for individuals and 85 percent for group coverage plans. Has HHS done premium impact analysis based on this change? If so, what were your results?

Answer 7. HHS anticipates that the transparency and standardization of MLR reporting in the interim final regulation will help consumers to ensure that they receive good value for their premium dollars. Additionally, the inclusion of activities that improve quality in calculating the MLR could help to increase the level of investment in and implementation of effective quality improvement activities, which could result in improved quality outcomes and lead to a healthier population. The department estimates that issuers’ total one-time administrative costs related to the MLR reporting, record retention, and rebate payment and notification requirements represent less than 0.02 percent of their total premiums for accident and health coverage, and their total annual ongoing administrative costs related to these requirements represent less than 0.01 percent of their total premiums for accident and health coverage. Executive Order 12866 also requires consideration of the “distributive impacts” and “equity” of a regulation. As described in the regulatory impact analysis (RIA) for the MLR regulation this regulatory action will help ensure that issuers spend at least a specified portion of premium income on reimbursement for clinical services and quality improving activities and will result in a decrease in the proportion of health insurance premiums spent on administration and profit. It will

require issuers to pay rebates to consumers if this standard is not met. Although we are unable to quantify benefits, the transfers (rebates from issuers to consumers) could be substantial—estimated monetized rebates of \$0.6 billion to \$1.4 billion annually.

Question 8. On June 18, 2010, I sent a letter to the then Centers for Medicare & Medicaid Services (CMS) Acting Administrator Marilyn Tavenner in reference to a request made by the American College of Radiology, the American Society of Radiologic Technologists and the American Registry of Radiologic Technologists in regard to the adjustment in supervision levels for Radiologist Practitioner Assistants and Registered Radiologist Assistants. What action has been taken in reference to my inquiry?

Answer 8. We appreciate your interest in CMS's policies regarding supervision levels for services performed by radiology practitioner assistants (RPAs) and registered radiologist assistants (RRAs). Currently, RPAs and RRAs may not bill Medicare separately for services that they provide. However, these services can be covered and paid under the diagnostic testing benefit category, as long as the appropriate level of supervision is provided by a qualified physician.

CMS carefully assigns physician supervision levels for diagnostic testing services, based in large part upon the judgment of our physician clinical advisors. At this time, CMS does not intend to make a change in the physician supervision requirements for services provided by RPAs and RRAs. However, our medical staff reviews these requirements on an ongoing basis. We are happy to continue to work with you and your staff on this issue.

Question 9a. I have had several constituents complain about the 2011 Physician Fee Schedule final rule policy requiring physician or qualified non-physician (NPP) signatures on requisitions for laboratory tests reimbursed under the clinical laboratory fee schedule. This rule recently adopted by the Centers for Medicare & Medicaid Services (CMS) could adversely affect patient care.

Why is CMS now requiring that doctors sign both the medical chart with the doctor's order and the requisition form for the lab test? What led CMS to conclude that one signature from the physician was not enough?

Answer 9a. The action taken in the CY 2011 Physician Fee Schedule final rule to require a physician's or qualified non-physician practitioner's (NPP) signature on laboratory requisitions followed earlier efforts in CY 2009 and CY 2010 to address the confusion that existed about when a signature was required and for what services. The requirement was also intended to respond to numerous stakeholder comments urging a consistent policy across Medicare benefits, since physician signatures are required for other types of diagnostic services. At the same time, CMS believed that it would not increase the burden on physicians because it was the agency's understanding that, in most instances, physicians are annotating the patient's medical record with either a signature or an initial (the "order"), as well as providing a signature on the paperwork that is provided to the clinical diagnostic laboratory that identifies the test or tests to be performed for a patient (the "requisition") as a matter of course. Further, CMS recognized that some practitioners use the patient's medical record as the order for laboratory services and the policy would not require such practitioners to also submit requisitions.

Because of concerns that some physicians, NPPs, and clinical diagnostic laboratories are not aware of, or do not understand, this policy, CMS focused its efforts in the first quarter of 2011 on developing educational and outreach materials to educate those affected by this policy. However, after further input from the laboratory community, CMS has decided to focus its resources for the remainder of 2011 on changing the regulation that requires signatures on laboratory requisitions because of concerns that physicians, NPPs, and clinical diagnostic laboratories are having difficulty complying with this policy.

Question 9b. Is CMS concerned that this could further increase the cost of care by having to have the doctor present twice? (Once to examine the patient and again when the test is administered; even though the test could be conducted hours or even a day later).

Answer 9b. The policy does not require the physician to be present when the test is performed. In fact, CMS believed that the policy would not increase the burden on physicians because it was the agency's understanding that, in most instances, physicians are annotating the patient's medical record with either a signature or an initial (the "order"), as well as providing a signature on the paperwork that is provided to the clinical diagnostic laboratory that identifies the test or tests to be performed for a patient (the "requisition") as a matter of course. Further, CMS recognized that some practitioners use the patient's medical record as the order for lab-

oratory services and the policy would not require such practitioners to also submit requisitions.

Question 9c. Did CMS consult with any providers to engage them on the discussion for this rule? If so, what was their response? If not, why didn't they?

Answer 9c. Yes. As mentioned above, CMS engaged in notice and comment rule-making to address the confusion that existed about when a signature was required and for what services in CY 2009 and CY 2010 before finalizing a policy in the CY 2011 Physician Fee Schedule final rule. The requirement was intended to respond to numerous stakeholder comments urging a consistent policy across Medicare benefits, since physician signatures are required for other types of diagnostic services. However, after further input from the laboratory community, CMS has decided to focus its resources for the remainder of 2011 on changing the regulation that requires signatures on laboratory requisitions because of concerns that physicians, NPPs, and clinical diagnostic laboratories are having difficulty complying with this policy.

Question 10. Why was meaningful tort reform left out of the 2010 Patient Protection and Affordable Care Act? Medical costs in our country are rising steadily and this is threatening access to services. Using Texas as a case study, it is fair to extrapolate that tort reform leads to cost saving and increases access. Additionally, a *CQ Today* article that ran on January 24, 2011, cites a Congressional Budget Office Estimate that medical malpractice reform could save \$54 billion over 10 years.

Why did PPACA choose to ignore this?

Answer 10. As the President noted in his State of the Union Address, the Administration strongly supports efforts to reduce health care costs, including considering ideas to rein in frivolous medical malpractice lawsuits. I agree that our medical liability system needs to be examined, to ensure that it improves the quality of care and patient safety, compensates patients in a fair and timely manner if they are harmed through medical negligence, reduces medical liability premiums and the costs associated with defensive medicine, and weeds out frivolous lawsuits.

As you know, prior to the enactment of the Affordable Care Act, the Administration established a \$25 million initiative to support efforts by States and health systems to develop, implement, and evaluate patient safety and medical liability reforms. This is the most ambitious effort to date by HHS to support and evaluate our medical liability system and patient safety reforms. It is also the largest government investment connecting medical liability to improving quality and avoiding harm rather than just negligence and punishment.

Building on that effort, the President's fiscal year 2012 Budget includes \$250 million in grants to States to reform their medical liability laws. The Department of Justice, in consultation with the HHS, will administer this program. The goal of these reforms would be to fairly compensate patients who are harmed by negligence, reduce providers' insurance premiums, weed out frivolous lawsuits, improve the quality of health care and patient safety, and reduce medical costs associated with "defensive medicine." States could propose reforms to their medical malpractice system through various approaches, such as health courts, safe harbors, early disclosure and offer, or other legal reforms.

Question 11. My office often meets with Nurses, Physicians Assistants and Tech Assistants. What is HHS/CMS doing to help work these professionals into the delivery system? Specifically, What is being done to evaluate on a national level how many responsibilities these professionals are capable of handling, in relation to their training levels?

What is being done on a national level to make sure these professionals are being used to their full capacity?

Tennessee has many rural and underserved populations. By maximizing the professionals mentioned above, we could increase access to care and lower costs. It is important for me to learn what initiatives the Secretary is taking to working these individuals into the delivery system, and to make sure there are qualified and certified professionals to deliver services in their care area.

Answer 11. The Administration believes that strengthening and growing the health care workforce is critical to reforming the Nation's health care system. Workforce initiatives funded by the Affordable Care Act include a strong focus on nurse practitioners and physician assistants. For instance, with \$30 million in Affordable Care Act funding, 600 new physician assistants will be fully trained by 2015. With \$31 million in Affordable Care Act funding, 600 new nurse practitioners and nurse midwives will be fully trained by 2015. In addition, the President's fiscal year 2012 budget proposes to begin a 5-year effort to fund the training of an additional 4,000 new primary care providers, including primary care physicians, nurse practitioners

and physician assistants. The Administration recognizes that these providers are an essential component in the health care delivery system. We also support the development of inter-professional training and of team-based care models, like medical homes, which involve health professionals practicing to the full extent of their training. To inform Federal, State and private sector workforce planning in the future, the President's budget also would enhance the efforts of the Health Resources and Services Administration's National Center for Health Workforce Analysis to collect and analyze data on the health care workforce supply, demand and capacity.

In addition to creating new training opportunities for nurse practitioners and physician assistants, the Affordable Care Act also invests in encouraging the placement of these providers in underserved areas. About half of National Health Service Corps clinicians, including physicians, advanced practice nurses, and physician assistants, work in Health Resources and Services Administration-supported health centers, which have a long record of success providing affordable, cost-effective, high quality preventive and primary care services to some of our Nation's most vulnerable individuals. The Affordable Care Act provided \$11 billion to bolster and expand Community Health Centers and \$1.5 billion for the National Health Service Corps over the next 5 years. In addition, the Affordable Care Act provided \$15 million to fund nurse-managed clinics, which provide primary care and wellness services to underserved and vulnerable populations, and are managed by advanced practice nurses, including nurse practitioners.

Question 12. Tennessee has many Veterans. My office has been hearing that for many of them, their local VA clinics or other government treatment centers is out of network for their carrier. Is this something into which your department is looking in coordination with the Department of Veterans Affairs to make sure our Veterans have access to care?

Answer 12. 38 U.S.C. §1729 provides VA the statutory authority to collect its billed charges or an amount a third party payer demonstrates it pays to non-governmental providers in the same geographic area for the same care and services. Federal law does not require third party payers to enter into agreements with VA. However, VA has found there are many benefits to entering into agreements with third party payers. Formal agreements have been established with several third party payers conducting business in Tennessee. Collectively, the third party payers with whom VA has entered into agreements, according to the 2010 Atlantic Information Systems Directory of Health Plans, covers over 80 percent of people enrolled in health insurance plans in the State. The third party payers doing business in Tennessee, with whom VA has formal agreements include: BlueCross BlueShield of Tennessee, Aetna, CIGNA, Great-West Healthcare, and United Healthcare. Moreover, VA has a legislative proposal in the fiscal year 2012 budget that would amend 38 U.S.C. §1729 to make VA a statutory participating provider with all health plans whether or not an agreement is in place with a health insurer or third party payer, thus preventing the effect of excluding coverage or limiting payment of charges for care.

The VA cannot bill Medicare or Medicaid.

SENATOR ROBERTS

Question 1. I was pleased to learn of President Obama's commitment through Executive order to require that Federal agencies ensure that regulations protect our safety, health and environment while promoting economic growth.

Based on that commitment I have 2 questions: first, are you at the stage where you can tell us what regulations HHS is planning to scrub or repeal because of this Executive order and what is the timeline for complying?

Answer 1. The President's Executive order requires each agency, including HHS, to conduct a retrospective review of existing significant regulations to identify those that can be modified, streamlined, harmonized with others, or eliminated in order to increase flexibility and reduce burdens and costs on the regulated community. Under that Order, the President directed agencies to develop a plan and submit that plan to OMB by May 18, 2011. The plan will include a preliminary list of regulations HHS will review pursuant to the Executive order over the next 2 years.

OIRA has notified the agencies that it will be working closely with them as they develop their respective plans to meet the May 18, 2011, deadline. HHS is actively engaged in that process and will have a draft plan to OIRA by the end of April. We expect to submit the final HHS plan by the May 18 deadline.

Question 2. We have heard many suggestions from health providers in Kansas—people from Kansas you have worked with and know—and we would be happy to

work with you to address their concerns. I think the example of the impact of regulations on the child-only market is a good one.

So my second question is, realistically, what are the chances based on the President's commitment that PPACA regulations will be changed or repealed?

Answer 2. HHS is committed to meeting both the spirit and intent of the President's Executive order. As the President sets forth, the retrospective review process will be an ongoing one—undertaken as part of a culture of regulatory review and revision.

Question 3. The Executive order says:

“In applying these principles, each agency is directed to use the best available techniques to quantify anticipated present and future benefits and costs as accurately as possible. Where appropriate and permitted by law, each agency may consider (and discuss qualitatively)”

and this is the part where I have the most concern, “*values that are difficult or impossible to quantify, including equity, human dignity, fairness, and distributive impacts.*”

Are you anticipating you will be able to determine which regulations, including recently released health reform regulations, HHS believes would fall under this exemption?

Answer 3. Along with every regulation, HHS submits a regulatory impact analysis that includes a discussion of costs and benefits of the regulation. However, determining the costs and benefits of a regulation over time can be tricky and difficult when it comes to assessing the impact of a regulation on the health and well-being of individuals over the long term. We do not read the President's Executive order to permit an exemption to the quantitative cost/benefit requirement. Rather, we believe the President permits agencies to discuss qualitative factors that are difficult or impossible to measure in quantitative terms, but which are nevertheless important in assessing the value of the regulation in improving the health and well-being of the American people.

Question 4. Beyond the 180 days with which your Agency would now have to provide a preliminary plan for the Executive order, what is the HHS timeline for complying with the intent of this Executive order and creating “a more cost-effective, transparent and smart regulatory system.” In short, how long is this expected to take, and when can Americans expect to see results?

Answer 4. Consistent with the President's directive, we expect that the process will not simply be a one-time exercise, but rather an ongoing process of review and change. The effort is to create a culture of review and revision, where existing regulations are routinely modified, streamlined, or eliminated where appropriate to achieve a better regulatory framework. We expect that the American people will see certain initial results within the next year. But we also expect to produce results year after year as these reviews become institutionalized as part of the review and revision process.

Question 5. Madam Secretary, as the former Governor of Kansas you are well aware that Kansas has 83 Critical Access Hospitals (CAHs)—the most of any State and fully ⅓ of our hospitals. And you also know that CAHs are not part of the 5-year exemption from IPAB review that other hospitals were given in health reform. Should IPAB recommend reductions that take funds away from these rural community hospitals I can assure you Congress will act, but would you support such a recommendation?

Answer 5. The Independent Payment Advisory Board is one of the key features of the Affordable Care Act that will set our system on a path to sustainability in the long run. The statute establishing the IPAB specifies that the Board recommend proposals that would “protect and improve Medicare beneficiaries' access to necessary and evidence-based items and services, including in rural and frontier areas.” In my experience, many of America's rural areas continue to be on the cutting edge, leading change and improvement in health care. I'm happy to talk to you or your staff about ways to ensure that critical access hospitals can continue to provide essential services in many rural areas of the country.

Question 6. It has recently been brought to my attention that there is a regulation related to the dialysis transition adjuster that I have been told, based on CMS inaccurate estimates, has resulted in underpayments for dialysis treatments. Is this one of the regulations CMS and HHS are considering revising?

Answer 6. When adopting a new payment system under Medicare, CMS is often statutorily required to ensure that aggregate payments (with the exception of any

applicable inflation update) are the same as those under the previous payment system. In this case, we were required to ensure that payments under the new ESRD prospective payment system (PPS) were, in aggregate, 98 percent of the total payments that would have been made under the previous basic case-adjusted composite payment system. In order to meet this requirement, we applied a transition budget neutrality adjustment factor of 3.1 percent to ESRD payments in the calendar year (CY 2011) ESRD PPS final rule.

As described in the final rule, CMS' calculation of this factor was based on the best available data to estimate payments during the transition period. At the same time, we acknowledged that the adjustment may not reflect actual choices made by the ESRD facilities regarding opting out of the ESRD PPS transition. However, we noted that the adjustment would be updated each year of the transition (CY 2012 and CY 2013) to reflect actual data on providers electing to opt-out of the transition.

We recently issued an interim final rule (76 Fed. Reg. 18930, April 6, 2011), in which we revised the ESRD transition budget-neutrality adjustment finalized in the CY 2011 ESRD Prospective Payments System final rule for renal dialysis services furnished April 1, 2011 through December 31, 2011, to reflect the actual election decisions of ESRD facilities for participating in the ESRD PPS transition.

Question 7. If CMS and the Department are unwilling or unable to exhibit the flexibility necessary to fix something as straight-forward as the dialysis transition adjuster then how can this committee and the American people be confident that the Department has the wherewithal to implement something as daunting and complex as the Affordable Care Act?

Answer 7. As we noted in our response to the previous question, we have already updated the dialysis transition adjuster in response to reasonable concerns from the dialysis provider industry. Additionally, CMS and the Department share your concerns and implementing the Affordable Care Act in a timely and transparent way is a high priority for the Administration. We have aggressively moved forward on a number of provisions that are already providing seniors with meaningful benefits.

The Administration and HHS remain committed to a transparent implementation process that includes feedback from stakeholders. For example, CMS has specifically requested comments on portions of the regulation implementing the Affordable Care Act provisions to counter fraud in the Medicare and Medicaid programs. Feedback, both from the notice and comment process and other outreach efforts, will continue to be a critical part of the Administration's implementation efforts.

Question 8. Madam Secretary, Dr. Berwick was renominated to be the CMS Administrator by the President. As a representative of your Department are you and your Administration committed to allowing or encouraging Dr. Berwick to testify before the relevant committees and answering all of the questions and concerns of the Members of the Senate during this nomination process? I think this is of particular importance considering the reorganization of OCHIO under CMS.

Answer 8. Across the Department, we are all focused on implementing the Affordable Care Act and bringing real benefits to all Americans. We are committed to our mission of ensuring access to and providing efficient, high-quality health care to our beneficiaries, and will continue to work with Congress in a bipartisan fashion to achieve this core goal.

Dr. Berwick has already testified before Congress and is fully committed to meeting with individual Senators to address all of their questions and any areas of concern.

SENATOR HATCH

Question 1. Currently the Institute of Medicine (IOM) is reviewing and will soon issue a list of specific mandatory benefits to meet the Patient Protection and Affordable Care Act's (PPACA) essential health benefits requirement. In general, when these mandates are implemented in 2014, will individuals living in States, like Utah, with fewer benefit mandates see an increase in premiums as a result of adding benefits that were previously not required to be covered?

Answer 1. The IOM will not be making recommendations on specific benefits or services. As they state on their Web site:

"The IOM will not define specific service elements of the benefit package. Instead, the IOM will review how insurers determine covered benefits and medical necessity and will provide guidance on the policy principles and criteria for the Secretary to take into account when examining QHPs for appropriate balance among categories of care; the health care needs of diverse segments of the population; and nondiscrimination based on age, disability, or expected length

of life. Additionally, the IOM may offer advice on criteria and a process for periodically reviewing and updating the benefits package.”

Question 2. Actuarial analysis by the Council for Affordable Health Insurance has found that individual benefit mandates, on average, increase premiums by between 1 and 3 percent. If the new benefit mandates coming out of the IOM exceed the number of benefits mandated in Utah, PPACA will force Utah constituents to pay higher premiums for benefits they may not need or want. To that end, can you confirm that States with few benefit mandates will see increases in premiums as a result of the essential health benefits requirement under PPACA?

Answer 2. As noted above, the IOM is not making recommendations on specific services. The Affordable Care Act defines essential health benefits to,

“include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.”

Question 3. Can you also confirm that as U.S. Preventive Services Task Force (USPSTF) continues to approve new A and B recommendations for preventive health benefits premiums will also continue to increase if the preventive benefit recommended is not already mandated or covered by a plan?

Answer 3. Too many Americans don’t get the preventive health care they need to stay healthy, avoid or delay the onset of disease, lead productive lives, and reduce health care costs. Cost-sharing (including copays, co-insurance and deductibles) reduces the likelihood that preventive services will be used. The Affordable Care Act is already helping to make wellness and prevention services affordable and accessible to individuals by requiring most health plans to cover preventive services and by eliminating cost-sharing. High-quality preventive care helps Americans stay healthy, avoid or delay the onset of disease, lead productive lives, and reduce costs. And yet, despite the proven benefits of preventive health services, too many Americans go without needed preventive care because of financial barriers. Even families with insurance may be deterred by copayments and deductibles from getting cancer screenings, immunizations for their children and themselves, and well-baby check-ups that they need to keep their families healthy.

Question 4. I was surprised by the announcement made by HHS on January 26, 2011, that a total of 948 waivers have been granted from the annual benefit limits established under PPACA. This waiver process obviously stands in stark contrast to the Administration’s claims about the value of PPACA in reducing costs and making health care more affordable. What is concerning about the announcement is the lack of transparency about the waiver process. If the new requirements under PPACA were meant to reduce costs and make health care more affordable and accessible, then why do these organizations need waivers to continue to keep costs down and provide access to insurance?

Answer 4. The Affordable Care Act is designed to provide Americans with affordable, high-quality coverage options—while ensuring that those who like their current coverage can keep it. Unfortunately, today, limited benefit plans, or “mini-med” plans are often the only type of insurance offered to some workers. In 2014, the Affordable Care Act will end most mini-med plans when Americans will have better access to affordable, comprehensive health insurance plans that cannot use high deductibles or annual limits to limit benefits. In the meantime, the law requires insurers to phase out the use of annual dollar limits on benefits. In 2011, most plans can impose an annual limit of no less than \$750,000.

Mini-med plans have lower limits than allowed under the Affordable Care Act. While mini-med plans do not provide security in the event of serious illness or accident, they are unfortunately the only option that some employers offer. In order to protect coverage for these workers, regulations allow these plans to apply for temporary waivers from rules restricting the size of annual limits to some group health plans and health insurance issuers.

Waivers only last for 1 year and are only available if the plan certifies that a waiver is necessary to prevent either a large increase in premiums or a significant decrease in access to coverage. In addition, enrollees must be informed that their plan does not meet the requirements of the Affordable Care Act. No other provision of the Affordable Care Act is affected by these waivers: they only apply to the annual limit policy.

Question 5. As States are facing a \$175 billion collective budget shortfall, we must provide them with the flexibility to find responsible ways to continue serving beneficiaries and to fulfill their constitutional requirements to balance their budgets. I appreciate your acknowledgement of the difficult budget circumstances States are facing, but I have heard from many States that your February 3, 2011, letter fails to provide the level of assistance that States desperately need. As you know, dozens of governors have asked for relief from the maintenance of effort (MOE) requirements in the Patient Protection and Affordable Care Act (PPACA) in order to responsibly manage their programs and even to make common-sense modernizations to their eligibility determination procedures. As you know, your waiver authority under Section 1115 of the Social Security Act allows you to waive certain provisions in Section 1902 of the Social Security Act. The MOE requirements included in the PPACA are in section 1902. I understand that you plan to look at each State's individual circumstances and specific budgetary pressures, however knowing that there is a \$175 billion collective State budget shortfall, do you anticipate granting *any* Section 1115 waivers from MOE restrictions for States to allow them greater flexibility in balancing their budgets?

Answer 5. HHS understands the challenges States are facing and we're ready to offer new approaches, listen to new ideas and conduct business with States in ways that are responsive to the severity and immediacy of these challenges. CMS recently sent a detailed letter to State Medicaid directors on February 25, 2011, clarifying situations in which the Affordable Care Act maintenance of effort provision does not apply. (Please visit the CMS Web site for a copy of the letter to States: <http://www.cms.gov/smdl/downloads/SMD11001.pdf>.) Specifically, in States that have or project budget deficits, the Affordable Care Act MOE requirements do not apply to certain adult populations, but the ARRA MOE does continue to apply through June 2011. The letter also provides additional information about the treatment of premiums and clarifies that the MOE provision in the Affordable Care Act also does not require a State to request that the Secretary continue a demonstration under section 1115 upon its expiration.

The new MOE guidance helps States in three ways. First, it serves as a reminder to States that are experiencing budget deficits of the ACA provision allowing them to seek an exemption from the ACA MOE requirement for certain adult populations (above 133 percent FPL). Second, it clarifies that States with 1115 waiver demonstration programs may allow those waivers to expire at the end of their waiver approval period without violating MOE. Third, it notes that some States may be able to increase premiums paid by Medicaid or CHIP beneficiaries.

We're also taking a number of steps to help States implement changes that will bring efficiencies to their Medicaid programs and improve the quality of care provided. CMS recently created the Medicaid State Technical Advisory Teams (M-STAT) that are responsible for offering States technical support and fast-track ways for them to implement new initiatives—particularly those targeted at ending the fragmented care provided to people dually eligible for Medicaid and Medicare that comprise a significant amount of Medicaid costs, lowering pharmacy costs and improving program integrity. These steps will strengthen the program over the long run, improve the quality and outcomes of care, and help States run more efficient Medicaid programs.

We look forward to continuing to work with States.

Location	Type	Entity	Total	Interpretation	EC	CP	Area evaluation (km2)	Area (km2)	CPW	AVL (km2)	NOT (km2)	AVP (km2)	CPW (km2)	AVL (km2)	NOT (km2)	AVP (km2)	Method	Health Care	Community Care	Workforce
Alabama	Alabama	ALABAMA STATE DEPT. OF PUBLIC HEALTH	3	424,985	200,000	161,729	5	5	2,000,000	138,713	165,437	5	742,973	5	5	5	5	5	5	5
Alaska	Alaska	ALASKA STATE DEPARTMENT OF HEALTH	3	311,407	145,000	117,407	5	5	5	41,450	5	5	5	5	5	5	5	5	5	5
Arizona	Arizona	ARIZONA STATE DEPT. OF HEALTH	3	1,047,400	500,000	417,500	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Arkansas	Arkansas	ARKANSAS STATE DEPARTMENT OF HEALTH	3	188,797	100,000	78,797	5	5	5	5	5	5	5	5	5	5	5	5	5	5
California	California	CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES	3	1,786,971	245,548	117,205	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Colorado	Colorado	COLORADO STATE DEPT. OF HEALTH	3	1,379,434	200,000	442,354	5	5	2,000,000	114,148	15	5	4,484	5	5	5	5	5	5	5
Connecticut	Connecticut	CONNECTICUT DEPARTMENT OF PUBLIC HEALTH	3	1,373,731	2,000,000	128,845	5	5	5	415,033	164,547	5	2,061,273	5	5	5	5	5	5	5
Delaware	Delaware	DELAWARE STATE DEPT. OF HEALTH	3	100,000	100,000	5	5	5	3,000,000	5	5	5	5	5	5	5	5	5	5	5
District of Columbia	District of Columbia	DISTRICT OF COLUMBIA DEPT. OF HEALTH	3	100,000	100,000	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Florida	Florida	FLORIDA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	414,000	5	5	5	130,343	165,547	5	1,838,400	5	5	5	5	5	5	5
Georgia	Georgia	GEORGIA STATE DEPT. OF HEALTH	3	1,300,447	1,000,000	1,000,000	5	5	5	271,484	165,547	5	807,264	5	5	5	5	5	5	5
Hawaii	Hawaii	HAWAII STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Idaho	Idaho	IDaho STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Illinois	Illinois	ILLINOIS STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Indiana	Indiana	INDIANA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Iowa	Iowa	IOWA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Kansas	Kansas	KANSAS STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Kentucky	Kentucky	KENTUCKY STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Louisiana	Louisiana	LOUISIANA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Maine	Maine	MAINE STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Maryland	Maryland	MARYLAND STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Massachusetts	Massachusetts	MASSACHUSETTS STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Michigan	Michigan	MICHIGAN STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Minnesota	Minnesota	MINNESOTA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Mississippi	Mississippi	MISSISSIPPI STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Missouri	Missouri	MISSOURI STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Montana	Montana	MONTANA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Nebraska	Nebraska	NEBRASKA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Nevada	Nevada	NEVADA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
New Hampshire	New Hampshire	NEW HAMPSHIRE STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
New Jersey	New Jersey	NEW JERSEY STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
New Mexico	New Mexico	NEW MEXICO STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
New York	New York	NEW YORK STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
North Carolina	North Carolina	NORTH CAROLINA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
North Dakota	North Dakota	NORTH DAKOTA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Ohio	Ohio	OHIO STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Oklahoma	Oklahoma	OKLAHOMA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Oregon	Oregon	OREGON STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Pennsylvania	Pennsylvania	PENNSYLVANIA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Rhode Island	Rhode Island	RHODE ISLAND STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
South Carolina	South Carolina	SOUTH CAROLINA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
South Dakota	South Dakota	SOUTH DAKOTA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Tennessee	Tennessee	TENNESSEE STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Texas	Texas	TEXAS STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Utah	Utah	UTAH STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Vermont	Vermont	VERMONT STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Virginia	Virginia	VIRGINIA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Washington	Washington	WASHINGTON STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
West Virginia	West Virginia	WEST VIRGINIA STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Wisconsin	Wisconsin	WISCONSIN STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5
Wyoming	Wyoming	WYOMING STATE DEPT. OF HEALTH	3	1,000,000	1,000,000	217,000	5	5	5	4,240	5	5	33,437	5	5	5	5	5	5	5

Location	Type	Entity	FY2014	Subsequent	ETC	OP	At-Risk population	ARC/ARC	CPW	NY LAB	NY Training	NY Planning	Outreach	Technical Media	National	Health Care	Community Outreach	Workforce
Alabama	State	ALABAMA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 24,831	\$ 20,000	\$ 79,548	-	-	-	-	-	-	-	\$ 84,000	-	-	-	-	-
Arkansas	State	ARKANSAS STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 74,437	\$ 20,000	\$ 389,395	-	-	-	-	-	-	-	\$ 72,880	-	-	-	-	-
California	State	CALIFORNIA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 86,488	\$ 200,000	\$ 289,279	-	-	-	-	-	-	-	\$ 71,031	-	-	-	-	-
Colorado	State	COLORADO STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 4,000	\$ 1,000,000	-	-	-	-	-	-	-	-	\$ 71,112	-	-	-	-	-
Connecticut	State	CONNECTICUT STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 3,425,966	\$ 1,324,345	\$ 215,410	-	-	-	-	-	-	-	\$ 51,099	-	-	-	-	-
Delaware	State	DELAWARE STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 30,000	\$ 200,000	-	-	-	-	-	-	-	-	-	-	-	-	-	-
District of Columbia	State	DISTRICT OF COLUMBIA DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Florida	State	FLORIDA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Georgia	State	GEORGIA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Hawaii	State	HAWAII STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Idaho	State	IDaho STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Illinois	State	ILLINOIS STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Indiana	State	INDIANA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Iowa	State	IOWA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Kansas	State	KANSAS STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Kentucky	State	KENTUCKY STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Louisiana	State	LOUISIANA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Maine	State	MAINE STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Maryland	State	MARYLAND STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Massachusetts	State	MASSACHUSETTS STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Michigan	State	MICHIGAN STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Minnesota	State	MINNESOTA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Mississippi	State	MISSISSIPPI STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Missouri	State	MISSOURI STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Montana	State	MONTANA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Nebraska	State	NEBRASKA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Nevada	State	NEVADA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
New Hampshire	State	NEW HAMPSHIRE STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
New Jersey	State	NEW JERSEY STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
New Mexico	State	NEW MEXICO STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
New York	State	NEW YORK STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
North Carolina	State	NORTH CAROLINA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
North Dakota	State	NORTH DAKOTA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Ohio	State	OHIO STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Oklahoma	State	OKLAHOMA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Oregon	State	OREGON STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Pennsylvania	State	PENNSYLVANIA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Rhode Island	State	RHODE ISLAND STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
South Carolina	State	SOUTH CAROLINA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
South Dakota	State	SOUTH DAKOTA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Tennessee	State	TENNESSEE STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Texas	State	TEXAS STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Utah	State	UTAH STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Vermont	State	VERMONT STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Virginia	State	VIRGINIA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Washington	State	WASHINGTON STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
West Virginia	State	WEST VIRGINIA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Wisconsin	State	WISCONSIN STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Wyoming	State	WYOMING STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Yukon-Charley	State	YUKON-CHARLEY STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Alaska	State	ALASKA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Arizona	State	ARIZONA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Arkansas	State	ARKANSAS STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
California	State	CALIFORNIA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Colorado	State	COLORADO STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Connecticut	State	CONNECTICUT STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Delaware	State	DELAWARE STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
District of Columbia	State	DISTRICT OF COLUMBIA DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Florida	State	FLORIDA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Georgia	State	GEORGIA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Hawaii	State	HAWAII STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Idaho	State	IDaho STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Illinois	State	ILLINOIS STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Indiana	State	INDIANA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Iowa	State	IOWA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Kansas	State	KANSAS STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Kentucky	State	KENTUCKY STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Louisiana	State	LOUISIANA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Maine	State	MAINE STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Maryland	State	MARYLAND STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Massachusetts	State	MASSACHUSETTS STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Michigan	State	MICHIGAN STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Minnesota	State	MINNESOTA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Mississippi	State	MISSISSIPPI STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Missouri	State	MISSOURI STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Montana	State	MONTANA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Nebraska	State	NEBRASKA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
Nevada	State	NEVADA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
New Hampshire	State	NEW HAMPSHIRE STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
New Jersey	State	NEW JERSEY STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
New Mexico	State	NEW MEXICO STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
New York	State	NEW YORK STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-	-	-	-	-
North Carolina	State	NORTH CAROLINA STATE DEPT OF HEALTH AND HUMAN SERVICES	\$ 2,000,000	\$ 200,000	\$ 215,410	-	-	-	-	-	-	-	\$ 79,135	-				

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Health Resources and Services Administration
Prevention Fund Awards
Nurse Managed Health Clinics

FY 2010 Prevention and Public Health Fund
Health Resources and Services Administration
Nurse Managed Health Clinics

Purpose: To provide federal funding to support the development and operation of Nurse-Managed Health Clinics (NMHC) to: 1) improve access to primary health care, disease prevention and health promotion in medically underserved areas (including enhancements of outreach strategies); 2) enhance nursing practice by increasing the number of structured clinical teaching sites for undergraduate and graduate nursing students; and 3) enhance electronic processes for establishing effective patient and workforce data collection systems. Under this program, the focus would support the training and practice development site for nurse practitioners to build the capacity of primary care provider workforce.

Awardees	City	State	Award Amount
The Regents of the University of California, San Francisco	San Francisco	CA	\$1,497,320
University of Colorado, Denver	Aurora	CO	\$1,498,206
University of Mississippi Medical Center	Jackson	MS	\$1,500,000
Regents of the Univ of Michigan	Ann Arbor	MI	\$1,498,577
East Tennessee State University	Johnson City	TN	\$1,400,998
Tides Center - Women's Community Clinic	San Francisco	CA	\$1,459,366
Fair Haven Community Health Clinic, Inc.	New Haven	CT	\$1,500,000
St. Mary's Health Wagon, Inc.	Clinchco	VA	\$1,493,634
University of Illinois at Chicago / The Board of Trustees of the University of Illinois	Chicago	IL	\$1,499,995
The University of Texas Medical Branch at Galveston	Galveston	TX	\$1,500,000
Total, Nurse Managed Health Clinics Grants			\$14,848,096
Other Grant Expenses			\$1,300
Total, Nurse Managed Health Clinics			\$14,849,396

Health Resources and Services Administration
Prevention Fund Awards
Primary Care Residency Expansion

FY 2010 Prevention and Public Health Fund
Health Resources and Services Administration
Primary Care Residency Expansion

Purpose: To increase the number of residents trained in primary care specialty - family medicine, general internal and general pediatric medicine. Funding may only be used to increase the enrollment in an accredited primary care residency program through resident stipend support.

Awardees	City	State	Award Amount
Regents of the University of Colorado	Aurora	CO	\$1,920,000
Variety Children's Hospital dba Miami Children's Hospital	Doral	FL	\$2,861,568
Meharry Medical College	Nashville	TN	\$2,880,000
University of Connecticut Health Center	Farmington	CT	\$1,890,723
University of Rochester	Rochester	NY	\$1,887,125
Board of Trustees of Southern Illinois University	Springfield	IL	\$1,869,763
University of Florida	Gainesville	FL	\$1,920,000
Swedish Covenant Hospital	Chicago	IL	\$960,000
Carilion Medical Center	Roanoke	VA	\$1,920,000
The Reading Hospital and Medical Center	Reading	PA	\$2,880,000
Children's Hospital & Research Center at Oakland	Oakland	CA	\$3,840,000
Providence St Peter Hospital	Olympia	WA	\$960,000
UMDNJ - Robert Wood Johnson Medical School	New Brunswick	NJ	\$960,000
Albert Einstein Healthcare Network	Philadelphia	PA	\$1,920,000
University of Arkansas for Medical Sciences	Little Rock	AR	\$1,520,001
University of Arkansas for Medical Sciences-Cancer Research Center	Little Rock	AR	\$1,520,001
Yellowstone City & County Health Department/Riverstone Health	Billings	MT	\$960,003
University of Arkansas for Medical Sciences-Cancer Research Center	Little Rock	AR	\$759,999
The Regents of the University of Michigan	Ann Arbor	MI	\$960,000
University of Arkansas	Little Rock	AR	\$759,999
The University of Texas Southwestern Medical Center at Dallas	Dallas	TX	\$1,920,000
University of Colorado Denver	Aurora	CO	\$1,920,000
The Regents of the University of California, San Francisco	San Francisco	CA	\$1,920,000
Regents of the University of California	Davis	CA	\$1,920,000
The Regents of the University of California, Los Angeles	Los Angeles	CA	\$1,920,000
University of Medicine and Dentistry of New Jersey	Stratford	NJ	\$1,920,000
Univ. of Mass. Medical School	Worcester	MA	\$960,000
The Regents of the University of California, San Francisco	San Francisco	CA	\$1,920,000
Children's Hospital of Pittsburgh of the UPMC Health System	Pittsburgh	PA	\$1,920,000
The Ohio State University	Columbus	OH	\$3,840,000

Health Resources and Services Administration
Prevention Fund Awards
Primary Care Residency Expan

Awardees	City	State	Award Amount
Boston Medical Center	Boston	MA	\$3,840,000
Idaho State University	Pocatello	ID	\$960,000
Community Hospitals Foundation	Indianapolis	IN	\$960,000
Curators, University of Missouri on behalf of UMKC	Kansas City	MO	\$1,920,000
Central Iowa Hospital Corporation	Des Moines	IA	\$1,920,000
Texas Tech Univ Health Sciences Center	Lubbock	TX	\$960,000
Community Health of Central Washington	Yakima	WA	\$1,920,000
Newark Beth Israel Medical Center	Newark	NJ	\$1,920,000
Baystate Medical Center	Springfield	MA	\$3,840,000
Virginia Commonwealth University	Richmond	VA	\$1,585,520
Variety Children's Hospital dba Miami Children's Hospital	Doral	FL	\$1,907,712
The Family Medicine Residency of Idaho, Inc.	Boise	ID	\$960,000
Board of Regents, University of Nevada, Reno	Reno	NV	\$960,000
Children's National Medical Center	Washington	DC	\$3,840,000
Tulane University, School of Medicine	New Orleans	LA	\$2,472,964
Baylor College of Medicine	Houston	TX	\$1,920,000
Catholic Healthcare West / St. Mary Medical Center	Long Beach	CA	\$1,920,000
Baylor Research Institute	Dallas	TX	\$960,000
Mount Auburn Hospital	Cambridge	MA	\$2,879,998
The Family Medicine Residency of Idaho, Inc.	Boise	ID	\$960,000
Cincinnati Children's Hospital Medical Center	Cincinnati	OH	\$1,872,024
Crozer-Chester Medical Center	Upland	PA	\$1,920,000
UPMC Presbyterian Shadyside	Pittsburgh	PA	\$960,000
Montefiore Medical Center	Bronx	NY	\$1,490,111
Freeman Oak Hill Health System	Joplin	MO	\$1,907,712
Texas Tech University Health Sciences Center	Lubbock	TX	\$1,920,001
Newark Beth Israel Medical Center	Newark	NJ	\$1,920,000
Spectrum Health Hospitals	Grand Rapids	MI	\$3,490,659
Regents of the University of California	San Francisco	CA	\$1,920,000
Cooper Health System D/B/A Cooper University Hospital	Camden	NJ	\$1,920,000
Group Health Cooperative	Seattle	WA	\$960,000
Medical University of South Carolina	Charleston	SC	\$1,920,000
Danbury Hospital	Danbury	CT	\$3,360,000
Kingsbrook Jewish Medical Center	Brooklyn	NY	\$2,880,000
Richmond Medical Center	Staten Island	NY	\$2,880,000
Johns Hopkins University	Baltimore	MD	\$3,839,998
The University of Illinois at Chicago	Chicago	IL	\$1,920,000
Bronx-Lebanon Hosp Ctr	Bronx	NY	\$2,880,000
Cooper Health System D/B/A Cooper University Hospital	Camden	NJ	\$1,920,000
Marshfield Clinic Research Foundation	Marshfield	WI	\$1,920,000
Bronx-Lebanon Hosp Ctr	Bronx	NY	\$2,880,000
Sisters of Charity Hospital	Buffalo	NY	\$1,912,499
Hennepin Healthcare System, Inc./Hennepin County Medical Center	Minneapolis	MN	\$1,918,827
Louisiana State University Health Science Center	New Orleans	LA	\$3,120,000
Curators, University of Missouri on behalf of UMKC	Kansas City	MO	\$1,920,000

Health Resources and Services Administration
Prevention Fund Awards
Primary Care Residency Expan

Awardees	City	State	Award Amount
Regents of University of California	La Jolla	CA	\$2,880,000
Marshfield Clinic Research Foundation	Marshfield	WI	\$1,920,000
Baystate Medical Center	Springfield	MA	\$2,880,000
University of North Carolina at Chapel Hill	Chapel Hill	NC	\$3,715,684
St. Elizabeth Medical Center	Utica	NY	\$1,920,000
New Hanover Regional Medical Center	Wilmington	NC	\$1,795,571
University of Pennsylvania	Philadelphia	PA	\$2,777,757
Subtotal, Primary Care Residency Expansion Grants			\$167,356,219
Other Grant Expenses			\$1,452,283
Total, Primary Care Residency Expansion			\$168,808,502

Health Resources and Services Administration
Prevention Fund Awards
Healthy Weight

FY 2010 Prevention and Public Health Fund
Health Resources and Services Administration
Healthy Weight Collaborative

Purpose: To create and manage a new Prevention Center for Healthy Weight to address obesity in children and families. The center will launch the Healthy Weight Collaborative to share evidence-based and promising community-based and clinical interventions in preventing and treating obesity.

Awardees	City	State	Award Amount
National Initiative for Children's Healthcare Quality	Boston	MA	\$4,983,638
Total, Healthy Weight Collaborative Grants			\$4,983,638
Other Grant Expenses			\$16,362
Total, Healthy Weight Collaborative			\$5,000,000

Health Resources and Services Administration
Prevention Fund Awards
Physician Assistant Training

FY 2010 Prevention and Public Health Fund
Health Resources and Services Administration
Physician Assistant Training

Purpose: To increase student enrollment in primary care physician assistant programs and graduates planning to practice primary care specialties.

Awardees	City	State	Award Amount
Lincoln Memorial University	Harrogate	TN	\$1,900,800
Miami Dade College Medical Center Campus	Miami	FL	\$641,520
Shenandoah University	Winchester	VA	\$1,069,200
University of Nebraska Medical Center	Omaha	NE	\$924,000
The University of Toledo Health Science Campus	Toledo	OH	\$1,009,880
Pace University	New York	NY	\$660,000
Duke University Medical Center	Durham	NC	\$1,320,000
University of Utah	Salt Lake City	UT	\$704,000
Union College	Lincoln	NE	\$792,000
University of New Mexico Health Sciences Center	Albuquerque	NM	\$204,239
Desales University	Center Valley	PA	\$704,000
Riverside Community College District/Moreno Valley Campus	Moreno Valley	CA	\$2,117,808
Methodist University, Inc.	Fayetteville	NC	\$1,188,000
University of Colorado Denver	Aurora	CO	\$855,360
Grand Valley State University	Grand Rapids	MI	\$1,791,720
University of Washington	Seattle	WA	\$1,980,000
University of Texas - Pan American	Edinburg	TX	\$1,980,000
Samuel Merritt College	Oakland	CA	\$1,232,000
State of Colorado for Red Rocks Community College	Lakewood	CO	\$399,495
Chatham University	Pittsburgh	PA	\$880,000
King's College	Wilkes Barre	PA	\$990,000
LeMoyne College	Syracuse	NY	\$1,056,000
New York Institute of Technology	Old Westbury	NY	\$855,360
University of New England	Biddeford	ME	\$990,000
The Research Foundation of SUNY	Albany	NY	\$2,046,528
University of Southern California	Los Angeles	CA	\$704,000
Marywood University	Scranton	PA	\$704,000
The Univ of Oklahoma Health Sciences Center	Oklahoma City	OK	\$418,171
Total, Physician Assistant Training Grants			\$30,118,081

Health Resources and Services Administration
Prevention Fund Awards
State Health Care Workforce Dvl

Health Resources and Services Administration
State Health Workforce Development Grants

Purpose: To enable State partnerships (1) to complete comprehensive health care workforce development planning and (2) to implement those plans or carry out activities as defined by the State application in order to address current and projected workforce demands within the State.

Awardees	City	State	Award Amount
Virginia State Department of Health	Richmond	VA	\$1,935,137
Univ of Wisconsin - Madison	Madison	WI	\$150,000
NJ Department of Labor and Workforce	Trenton	NJ	\$150,000
District of Columbia Department of Employment Services	Washington	DC	\$149,250
Idaho Department of Labor	Boise	ID	\$150,000
University of North Dakota	Grand Forks	ND	\$150,000
MN Department of Employment and Economic Development	Saint Paul	MN	\$149,599
Maryland Governor's Workforce Investment Board	Baltimore	MD	\$150,000
State of Ohio - Department of Health	Columbus	OH	\$150,000
Wyoming Department of Workforce Services	Cheyenne	WY	\$149,396
Nevada Dept of Employment, Training, and Rehabilitation	Carson City	NV	\$149,999
Montana State University	Bozeman	MT	\$150,000
Connecticut Employment & Training Commission	Wethersfield	CT	\$150,000
North Carolina Department of Commerce Division of Workforce Development	Raleigh	NC	\$144,595
Colorado Department of Public Health and Environment	Denver	CO	\$150,000
University of Vermont	Burlington	VT	\$131,786
New Mexico Department of Labor	Albuquerque	NM	\$150,000
Hawaii Department of Labor and Industrial Relations	Honolulu	HI	\$150,000
New York State Department of Labor	Albany	NY	\$150,000
California Department of Employment Development	Sacramento	CA	\$150,000
Alaska Department of Labor and Workforce Development, ESD	Juneau	AK	\$150,000
Commonwealth Corporation	Boston	MA	\$149,271
South Carolina Department of Employment and Workforce	Columbia	SC	\$114,604
Kansas Department of Commerce	Topeka	KS	\$150,000
Pennsylvania Department of Labor & Industry	Harrisburg	PA	\$150,000
Maine Jobs Council	Augusta	ME	\$150,000
Total, State Health Workforce Development Grants			\$5,623,637

Health Resources and Services Administration
Prevention Fund Awards
Nurse Practitioner Traineeships

FY 2010 Prevention and Public Health Fund
Health Resources and Services Administration
Nurse Practitioner Traineeships

Purpose: To provide financial support through traineeships for registered nurses enrolled in advanced education nursing programs to prepare nurse practitioners, clinical nurse specialists, nurse-midwives, nurse anesthetists, nurse administrators, nurse educators, public health nurses and nurses in other specialties determined by the Secretary to require advanced education.

Awardees	City	State	Award Amount
Case Western Reserve Univ	Cleveland	OH	\$1,425,600
Univ of Utah	Salt Lake City	UT	\$1,425,600
Western Univ of Health Sciences	Pomona	CA	\$1,056,000
Univ of Oklahoma Health Sciences Center	Oklahoma City	OK	\$807,840
Florida State University	Tallahassee	FL	\$1,425,600
East Tennessee State University	Johnson City	TN	\$1,425,600
Univ of Illinois at Chicago /The Board of Trustees of the University of Illinois	Chicago	IL	\$1,425,600
West Virginia University Rsch Corp	Morgantown	WV	\$950,400
Shenandoah Univ	Winchester	VA	\$1,188,000
Univ of Massachusetts Medical School	Worcester	MA	\$760,816
Univ of Detroit Mercy	Detroit	MI	\$760,320
Pace Univ	New York	NY	\$1,425,600
Wayne State University	Detroit	MI	\$1,320,000
Oregon Health & Science University	Portland	OR	\$1,283,040
Michigan State Univ	East Lansing	MI	\$1,425,600
Trustees of the Univ of Pennsylvania	Philadelphia	PA	\$950,400
College of St. Scholastica	Duluth	MN	\$1,330,560
Georgia State Univ Research Foundation, Inc.	Atlanta	GA	\$831,600
The University of Michigan-Flint	Flint	MI	\$1,425,600
Univ of Texas Health Science Center at San Antonio	San Antonio	TX	\$1,425,600
Rutgers, The State University	Newark	NJ	\$807,840
University of Miami	Miami	FL	\$704,000
Duke Univ School of Nursing	Durham	NC	\$1,276,000
The Pennsylvania State Univ	University Park	PA	\$1,335,840
Daemen College	AMHERST	NY	\$1,425,600
Medical Univ of South Carolina	Charleston	SC	\$1,425,600
Total, Nurse Practitioner Traineeship Grants			\$31,044,256

Health Resources and Services Administration
Prevention Fund Awards
Nutrition, Physical Activity

FY 2010 Prevention and Public Health Fund
Health Resources and Services Administration
Nutrition, Physical Activity, & Screen Time Standards

Purpose: To identify content and strategies to assist States and selected Territories, child care providers and early educators, as well as families of young children, in preventing childhood obesity.

Awardees	City	State	Award Amount
University of Colorado HSC	Aurora	CO	\$249,000
Total, Nutrition, Physical Activity, and Screen Time Stds Grants			\$249,000
Other Grant Costs			\$6,000
Total, Nutrition, Physical Activity, and Screen Time Stds			\$255,000

Health Resources and Services Administration
Prevention Fund Awards
Public Health Training Centers

FY 2010 Prevention and Public Health Fund
Health Resources and Services Administration
Public Health Training Centers

Purpose: To improve the Nation's public health system by strengthening the technical, scientific, managerial, and leadership competence of the current and future public health workforce. A public health training center plans, develops, operates, and evaluates projects that are in furtherance of the goals established by the Secretary in the areas of preventive medicine, health promotion and disease prevention, or improving access to and quality of health services in medically underserved communities.

Organization Name	City	State	Total
University of South Florida	Tampa	FL	\$650,000
UMDNJ-School of Public Health	New Brunswick	NJ	\$647,654
The Research Foundation of SUNY	Albany	NY	\$649,921
INDIANA UNIVERSITY	Indianapolis	IN	\$129,267
University of Puerto Rico Medical Sciences Campus	San Juan	PR	\$650,000
University of Kentucky Research Foundation	Lexington	KY	\$647,307
The Regents of the University of California	Berkeley	CA	\$649,819
The University of Georgia	Athens	GA	\$630,032
Arizona Board of Regents	Tucson	AZ	\$647,637
The Univ of Texas Health Science Center at Houston	Houston	TX	\$649,801
Trustees of Boston University, BUMC	Boston	MA	\$649,977
Eastern Virginia Medical School	Norfolk	VA	\$488,360
University of Colorado Denver	Aurora	CO	\$649,497
Trustees of Dartmouth College	Hanover	NH	\$618,734
East Tennessee State Univ	Johnson City	TN	\$650,000
Regents of the University of California, Los Angeles	Los Angeles	CA	\$650,000
Univ of Pittsburgh	Pittsburgh	PA	\$649,994
University of Washington	Seattle	WA	\$650,000
The University of Oklahoma Health Sciences Center	Oklahoma City	OK	\$649,750
Board of Regents of the University of Wisconsin System	Madison	WI	\$628,480
University of South Carolina	Columbia	SC	\$650,000
Emory University	Atlanta	GA	\$650,000
The Regents of the Univ of Michigan	Ann Arbor	MI	\$650,000
Univ of North Carolina at Chapel Hill	Chapel Hill	NC	\$643,004
Total, Public Health Training Centers			\$14,829,234

HHS Centers for Disease Control and Prevention
FY 2010 Prevention and Public Health Fund Programs

Funded Program and Purpose

GRANT MECHANISM	
Infrastructure	Public Health Infrastructure (CDC: \$50 million). Support State, local, and Tribal public health infrastructure such as information technology and data systems, workforce training, and regulation and policy development.
ELC	Epidemiology and Laboratory Capacity Grants (CDC: \$20 million). Support State and local capacity to prevent, detect, and respond to infectious disease outbreaks.
EIP	
ARRA evaluation (BREES)	Communities Putting Prevention to Work (CDC: \$44 million). Award quality, unfunded awards to communities and States to implement evidence-based interventions to address tobacco and obesity. Support related evaluation and media activities.
ARRA Media	
CPFW	
HIV Lab	
HIV Testing	HIV/AIDS (CDC: \$30 million). The HHS allocation supports the National HIV/AIDS Strategy by investing in HIV/AIDS prevention activities, including increased testing.
HIV Planning	
Quitline	Tobacco Quitlines (CDC: \$5 million). Fund telephone-based tobacco cessation services.
Tobacco Media	National Media Campaign on Tobacco Use (CDC: \$10 million). Execute a media campaign targeting negative health consequences of tobacco use for youth and adults using traditional and social media strategies. Traditional (print, TV, radio, billboard) and social media strategies.
National Strategy	National Prevention Strategy (CDC: \$0.1 million). Support CDC's development of the National Prevention Strategy.
Health Care Surveillance	Health Care Surveillance (CDC: \$19.9 million). Support the collection of baseline data through National Health Interview Survey, the National Ambulatory Medical Care Survey (NAMCS), and the National Hospital Ambulatory Medical Care Survey (NHAMCS).
Community Guide	Community Preventive Services Task Force (CDC: \$5 million). Strengthen CDC's Community Guide by supporting the Task Force on Community Preventive Services in completing more systematic reviews and in increasing and evaluating the recommendations. The Community Guide and the Task Force recommendations inform policymakers, practitioners, and other decision makers.
Workforce	Public Health Workforce (CDC: \$8 million). Expand CDC public health workforce programs to increase the number of fellows trained and placed in public health positions.

HHS Office of the Secretary
Assistant Secretary for Public Affairs; Assistant Secretary for Planning and Evaluation
Prevention Fund Expenditures
(WHOLE DOLLARS)

ASPA	Appropriated	\$9,120,000			\$9,120,000
	Obesity Advertising Campaign		\$9,007,056	\$112,944	\$112,944
ASPE	Appropriated	\$100,000			\$100,000
	Healthy Living Innovation Awards		\$100,000		\$0
					\$0
					\$0
					\$0
					\$0

Total Available In Appropriation Transfer	\$9,220,000
Obligation Total in FY 2010	\$9,107,056
Lapse (Unobligated)	-\$112,944

**FY 2010 Prevention and Public Health Fund Obligations, Office of the Assistant Secretary of Health
(OASH)**

Categories of Expenditures	Tobacco Cessation	President's Council on Fitness	Strategic Planning	Total
Personnel Compensation	165,931.47	-	-	165,931.47
Personnel Benefits	59,829.65	-	-	59,829.65
Travel	13,650.27	-	-	13,650.27
Contracts	660,000.00	925,000.00	854,585.01	2,439,585.01
Cooperative agreement with the Association For Prevention Teaching and Research	-	-	138,000.00	138,000.00
Total	899,411.39	925,000.00	992,585.01	2,816,996.40

PURPOSES:

- **Tobacco Cessation (OASH: \$0.9 million).** Implement tobacco cessation activities, such as reducing tobacco use among low social economic status women of childbearing age, reducing the impact of tobacco use on their children, and other outreach efforts.

- **President's Council on Fitness Sports and Nutrition (OASH \$.9 million):** OASH coordinates all obesity activities. Activities include the Let's Move Ambassador Program; the President's Active Lifestyle Awards Program; the Youth Empowerment Program, and support for a Leadership Development Series for the Council.

- **Strategic Planning (OPHS: \$1 million).** Supports strategic planning within the Office of Public Health and Science, such as support for the National Prevention, Health Promotion, and Public Health Council and Advisory Group in section 4001 of the Affordable Care Act.

**FY 2010 Prevention and Public Health Fund
Substance Abuse and Mental Health Services Administration
Primary and Behavioral Health Care Integration (PBHCI)**

Purpose: To improve the overall wellness and physical health status of people with serious mental illnesses by making available coordinated primary care services in community mental health and other community-based behavioral health settings.

Awardees	City	State	Award Amount
Grants			
Alaska Island Community Services	Wrangell	AK	\$296,836
Community Mental Health Affiliates, Inc.	New Britain	CT	\$496,863
Asian Community Mental Health Board	Oakland	CA	\$496,863
County of San Mateo	San Mateo	CA	\$496,307
Glenn County Health Services Agency	Willows	CA	\$496,863
Tarzana Treatment Centers, Inc.	Tarzana	CA	\$496,862
Apalachee Center, Inc.	Tallahassee	FL	\$496,863
Coastal Behavioral Healthcare, Inc.	Sarasota	FL	\$496,863
Community Rehab Center (CRC), Inc.	Jacksonville	FL	\$496,862
Lakeside Behavioral Healthcare, Inc.	Orlando	FL	\$448,343
LifeStream Behavioral Center	Leesburg	FL	\$496,862
Miami Behavioral Health Center, Inc.	Miami	FL	\$496,863
Cobb County Community Services Board	Smyrna	GA	\$496,825
Heritage Behavioral Health Center, Inc.	Decatur	IL	\$496,863
Trilogy, Inc.	Chicago	IL	\$421,263
Adult and Child Mental Health Center, Inc.	Indianapolis	IN	\$495,189
Community Healthlink, Inc.	Worcester	MA	\$460,690
Family Services, Inc.	Gaithersburg	MD	\$490,868
Community Health and Counseling Services	Bangor	ME	\$496,820
Washtenaw Community Health Organization	Ypsilanti	MI	\$496,862
Catholic Charities, Diocese of Trenton	Trenton	NJ	\$496,862
Bronx Lebanon Hospital Center	Bronx	NY	\$496,135
Postgraduate Center for Mental Health	New York	NY	\$496,372
St. Barnabas Hospital	Bronx	NY	\$496,863
Greater Cincinnati Behavioral Health Services	Cincinnati	OH	\$492,511
North Oklahoma County Mental Health Center	Oklahoma City	OK	\$496,863
Horizon House, Inc.	Philadelphia	PA	\$481,562
Kent Center for Human and Organizational Development	Warwick	RI	\$496,636
South Carolina Department of Mental Health	Columbia	SC	\$471,654
Austin Travis County MH/MR Center	Austin	TX	\$494,900
Weber Human Services	Ogden	UT	\$496,862
Asian Counseling and Referral Services	Seattle	WA	\$496,863
Downtown Emergency Services Center	Seattle	WA	\$482,394
Prestera Center for Mental Health Services, Inc.	Huntington	WV	\$438,513
Subtotal, PBHCI Grants			\$16,403,620
Technical Assistance Contract			
National Council for Community Behavioral Healthcare	Washington	DC	\$3,596,380
Subtotal, PBHCI Technical Assistance Contracts			\$3,596,380
Total, Primary and Behavioral Health Care Integration			\$20,000,000

**FY 2010 Prevention and Public Health Fund
Agency for Healthcare Research and Quality**

Purpose: U.S. Preventive Services Task Force (USPSTF): Increase evidence reviews of the Task Force; improve the transparency and public involvement in the processes of the Task Force; and increase communication support (translation of products and outreach) for the Task Force.			
Awardees	City	State	Award Amount
Contracts			
ABT Associates, Inc. (Specialized Communications for USPSTF)	Cambridge	MA	\$4,000,000
Oregon Evidence-based Practice Center (EPC) for USPSTF Reviews	Portland	OR	\$1,010,937
Total, USPSTF			\$5,010,937

Purpose: Healthy Weight Practice-Based Research Networks: Fund practice-based research to identify and test models linking clinical and community based prevention to address obesity in practice settings.			
Awardees	City	State	Award Amount
Contract			
Colorado Practice-based Research Network (PBRN)- Healthy Weight	Denver	CO	\$489,063
Total, Healthy Weight PBRN			\$489,063

**Health Resources and Services Administration
Prevention Fund by Object Class Expenditure
(WHOLE DOLLARS)**

OA	Healthy Weight Collaborative Grant	\$4,983,638	\$16,362	\$5,000,000
MCHB	Nutrition, Physical Activity, & Screen Time Standards	\$249,000	\$6,000	\$255,000
BHPR	State Health Care Workforce Development Grants	\$5,623,637	\$126,363	\$5,750,000
BHPR	Primary Care Residencies	\$167,356,219	\$1,452,283	\$168,808,502
BHPR	Physician Assistant Training	\$30,118,081	\$0	\$30,118,081
BHPR	Traineeships for Nurse Practitioner Students	\$31,044,256	\$0	\$31,044,256
BHPR	Nurse Managed Care Centers	\$14,848,096	\$1,300	\$14,849,396
BHPR	Public Health Training Center Program	\$14,829,234	\$0	\$14,829,234

Total Available In Appropriation Transfer	\$270,655,000
Obligation Total in FY 2010	\$270,654,469
Lapse (Unobligated)	-\$531

SOLICITATION/CONTRACT ORDER FOR COMMERCIAL ITEM		7. ACQUISITION NUMBER		PAGE OF	
OFFEROR TO COMPLETE (BLOCKS 1A, 17, 22, 24, & 25)		OS42287		1 20	
2. CONTRACT NO. CS-10F-0098W		3. AWARD EFFECTIVE DATE 09/30/2010		4. ORDER NUMBER HBSF233201000693G	
5. SOLICITATION NUMBER CS-10F-0098W		6. SOLICITATION DATE 09/30/2010		7. OFFER DUE DATE/LOCAL TIME	
8. FOR SOLICITATION INFORMATION CALL: A. NAME KEVIN MCGOWAN		B. TELEPHONE NUMBER (No collect area)		C. OFFER DUE DATE/LOCAL TIME	
9. ISSUED BY DHHS/PSC/SAS/DAM Parklawn Building, Room 5C-16 5600 Fishers Lane MD Rockville 20857		10. THIS ACQUISITION IS X UNRESTRICTED OR <input type="checkbox"/> SET ASIDE FOR: <input type="checkbox"/> SMALL BUSINESS <input type="checkbox"/> SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS <input type="checkbox"/> HUBBARD SMALL BUSINESS <input type="checkbox"/> SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS		11. DELIVERY FOR POST DISTRIBUTION UNLESS BLOCK 11 IS MARKED <input type="checkbox"/> DELIVERY SCHEDULE	
12. DELIVER TO Office of the Secretary Office of the Secretary 200 Independence Ave., S.W. Washington DC 20201		13. THIS CONTRACT IS A FIXED ORDER UNDER OTHER (If not 100)		14. METHOD OF SOLICITATION <input type="checkbox"/> BIDDING <input type="checkbox"/> RFQ <input type="checkbox"/> IFB	
15. CONTRACTOR OFFICER CODE 1368146 FACILITY CODE KNOWLEDGE NETWORKS, INC. 1368146 KNOWLEDGE NETWORKS, INC. 1350 1350 WILLOW RD STE 102 CA MENLO PARK 940251516		16. ADMINISTERED BY DHHS/PSC/SAS/DAM Parklawn Bldg., Room 5C-16 5600 Fishers Lane MD Rockville 20857		17. PAYMENT WILL BE MADE BY CODE FMS FMS 5600 FISHERS LANE PARKLAWN BUILDING ROOM 15A-12 ROCKVILLE MD 20857	
18. CHECK IF PERMITTEE IS DIFFERENT AND PUT SUCH ADDRESS IN OFFER		19. SUBMIT OFFERS TO ADDRESS SHOWN IN BLOCK 16A UNLESS BLOCK 16B IS CHECKED			
20. SCHEDULE OF SUPPLIES/SERVICES		21. QUANTITY			
22. UNIT		23. UNIT PRICE			
24. AMOUNT		25. TOTAL AWARD AMOUNT (For Govt. Use Only)			
26. ACCOUNTING AND APPROPRIATION DATA 2010-1999AS9-25106		\$1,474,240.00			
27a. SOLICITATION INCORPORATES BY REFERENCE FAR 52.212-1, 52.212-4, FAR 52.213-5 AND 52.213-6 ARE ATTACHED. ADDENDUM		27b. CONTRACT/PURCHASE ORDER INCORPORATES BY REFERENCE FAR 52.212-4, FAR 52.213-5 IS ATTACHED. ADDENDUM			
28a. CONTRACTOR IS REQUIRED TO SIGN THIS DOCUMENT AND RETURN COPIES TO ISSUING OFFICE. CONTRACTOR AGREES TO FURNISH AND DELIVER ALL ITEMS SET FORTH OR OTHERWISE IDENTIFIED ABOVE AND ON ANY ADDITIONAL SHEETS SUBJECT TO THE TERMS AND CONDITIONS SPECIFIED HEREIN.		28b. AWARD OF CONTRACT REF. DATED YOUR OFFER ON SOLICITATION (BLOCK 6), INCLUDING ANY ADDITIONS OR CHANGES WHICH ARE SET FORTH HEREIN IS ACCEPTED AS TO ITEMS:			
29a. NAME AND TITLE OF OFFEROR (Type or print) J. M. DENNIS Government & Academic Research Knowledge Networks Inc. info@knowledge-networks.com		29b. DATE SIGNED 9/30/2010		29c. NAME OF CONTRACTING OFFICER (Type or print) KEVIN R. MCGOWAN	
30a. DATE SIGNED SEP 30 2010		30b. DATE SIGNED SEP 30 2010			

19 ITEM NO.	20 SCHEDULE OF SUPPLIES/SERVICES	21 QUANTITY	22 UNIT	23 UNIT PRICE	24 AMOUNT
1	<p>Survey on Long-Term Care Awareness and Planning</p> <p>Attached SOW is hereby incorporated in its entirety.</p> <p>Vendor quote dated September 29, 2010 is hereby incorporated by reference.</p> <p>900 PROJECT OFFICER AUTHORITY</p> <p>The Project Officer listed above is hereby designated to monitor the performance of this order on behalf of the Government. The Project Officer will provide no supervisory or instructional assistance to Contractor personnel. The Project Officer's function is primarily to provide the Contractor with working data. The Project Officer is not empowered to make any commitments, nor authorized to make any changes which affect prices, terms, or delivery as specified on this order. Any such proposed changes shall be brought to the immediate attention of the Ordering Officer for action. The acceptance of any change by the Contractor without specific approval and written consent of the Ordering Officer will be at the Contractor's own risk.</p> <p>929 INVOICE INFORMATION/CLAUSES INCORPORATED BY REFERENCE</p> <p>1. INVOICE INFORMATION</p> <p>IN ADDITION TO THE INFORMATION REQUIRED BY 52.232-25 (PROMPT PAYMENT), YOUR INVOICE MUST CONTAIN THE FOLLOWING: TAX IDENTIFICATION NUMBER (EMPLOYER'S IDENTIFICATION NUMBER) OR SOCIAL SECURITY NUMBER.</p> <p>2. CLAUSES INCORPORATED BY REFERENCE (FAR 52.252-2) (FEB 1998)</p> <p>Continued ...</p>				1,474,240.00

32a. QUANTITY IN COLUMN 21 HAS BEEN ☐ RECEIVED ☐ INSPECTED ☐ NOTED. ACCEPTED, AND CONFORMS TO THE CONTRACT, EXCEPT AS

32b. SIGNATURE OF AUTHORIZED GOVERNMENT REPRESENTATIVE _____ 32c. DATE _____ 32d. PRINTED NAME AND TITLE OF AUTHORIZED GOVERNMENT REPRESENTATIVE _____

32e. MAILING ADDRESS OF AUTHORIZED GOVERNMENT REPRESENTATIVE _____ 32f. TELEPHONE NUMBER OF AUTHORIZED GOVERNMENT REPRESENTATIVE _____

32g. E-MAIL OF AUTHORIZED GOVERNMENT REPRESENTATIVE _____

33. SHIP NUMBER _____ 34. VOUCHER NUMBER _____ 35. AMOUNT VERIFIED CORRECT FOR _____ 36. PAYMENT ☐ COMPLETE ☐ PARTIAL ☐ FINAL 37. CHECK NUMBER _____

38. GR ACCOUNT NUMBER _____ 39. GR VOUCHER NUMBER _____ 40. PAID BY _____

41a. I CERTIFY THIS ACCOUNT IS CORRECT AND PROPER FOR PAYMENT _____ 41b. SIGNATURE AND TITLE OF CERTIFYING OFFICER _____ 41c. DATE _____

42a. RECEIVED BY (Print) _____ 42b. RECEIVED AT (Location) _____ 42c. DATE RECD (YYMMDD) _____ 42d. TOTAL CONTAINERS _____

CONTINUATION SHEET		REFERENCE NO. OF DOCUMENT BEING CONTINUED GS-10F-0098W/HHSP233201000693G		PAGE OF 3 20	
NAME OF OFFEROR OR CONTRACTOR KNOWLEDGE NETWORKS, INC. 1368146					
ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	<p>THIS CONTRACT INCORPORATES ONE OR MORE CLAUSES BY REFERENCE, WITH THE SAME FORCE AND EFFECT AS IF THEY WERE GIVEN IN FULL TEXT. UPON REQUEST, THE CONTRACTING OFFICER WILL MAKE THEIR FULL TEXT AVAILABLE. ALSO, THE FULL TEXT OF A CLAUSE MAY BE ACCESSED ELECTRONICALLY AT THIS ADDRESS: HTTPS://WWW.ACQUISITION.GOV/FAR</p> <p>FEDERAL ACQUISITION REGULATION (48 CFR CHAPTER 1) CLAUSES</p> <p>FAR 52.246-4, Inspection of Services Fixed Price (AUG 1996)</p> <p>FAR 52.217-8 Option to extend services * 30 days (NOV 1999)</p> <p>FAR 52.232-33 PAYMENT BY ELECTRONIC FUNDS TRANSFER - CENTRAL CONTRACTOR REGISTRATION (OCT 2003)</p> <p>52.224-2 PRIVACY ACT (APR 1984)</p> <p>CLAUSE INCORPORATED BY FULL TEXT (52.212-5)</p> <p>Contract Terms and Conditions Required to Implement Statutes or Executive Orders -- Commercial Items (Jul 2010)</p> <p>(a) The Contractor shall comply with the following Federal Acquisition Regulation (FAR) clauses, which are incorporated in this contract by reference, to implement provisions of law or Executive orders applicable to acquisitions of commercial items:</p> <p>(1) 52.222-50, Combating Trafficking in Persons (Feb 2009) (22 U.S.C. 7104(g)).</p> <p>[] Alternate I (Aug 2007) of 52.222-50 (22 U.S.C. 7104(g)).</p> <p>(2) 52.233-3, Protest After Award (AUG 1996) (31 U.S.C. 3553).</p> <p>(3) 52.233-4, Applicable Law for Breach of Contract Claim (OCT 2004) (Pub. L. 108-77, 108-78).</p> <p>(b) The Contractor shall comply with the FAR clauses in this paragraph (b) that the Contracting Officer has indicated as being incorporated in this contract by reference to implement provisions of law or Executive orders applicable to acquisitions of commercial items:</p> <p>[Contracting Officer check as appropriate.]</p> <p>[] (1) 52.203-6, Restrictions on Subcontractor Sales to the Government (Sept 2006), with Alternate I (Oct 1995) (41 U.S.C. 253g and 10 U.S.C. 2402).</p> <p>[] (2) 52.203-13, Contractor Code of Business Ethics and Conduct (Apr 2010) (Pub. L. 110-252, Title VI, Chapter 1 (41 U.S.C. 251 note)).</p> <p>[] (3) 52.203-15, Whistleblower Protections under the American Recovery and Reinvestment Act of 2009 (June 2010) (Section 1553 of Pub. L. 111-5). (Applies to contracts funded by the American Recovery and Reinvestment Act of 2009.</p> <p>[] (4) 52.204-10, Reporting Executive Compensation and First-Tier Subcontract Awards (Jul 2010) (Pub. L. 109-282) (31 U.S.C. 6101 note)</p> <p>[] (5) 52.204-11, American Recovery and Reinvestment Act-Reporting Requirements</p> <p>Continued ...</p>				

CONTINUATION SHEET		REFERENCE NO. OF DOCUMENT BEING CONTINUED		PAGE	OF
		GS-10F-0098W/HHSP233201000693G		4	20
NAME OF OFFEROR OR CONTRACTOR					
KNOWLEDGE NETWORKS, INC. 1368146					
ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Jul 2010) (Pub. L. 111-5).				
	[] (6) 52.217-8 Option to extend services (Nov 1999)				
	[] (7) 52.219-3, Notice of Total HUBZone Set-Aside (Jan 1999) (15 U.S.C. 657a).				
	[] (8) 52.219-4, Notice of Price Evaluation Preference for HUBZone Small Business Concerns (JULY 2005) (if the offeror elects to waive the preference, it shall so indicate in its offer) (15 U.S.C. 657a).				
	[] (9) [Reserved]				
	[] (10) (i) 52.219-6, Notice of Total Small Business Set-Aside (June 2003) (15 U.S.C. 644).				
	[] (ii) Alternate I (Oct 1995) of 52.219-6.				
	[] (iii) Alternate II (Mar 2004) of 52.219-6.				
	[] (11) (i) 52.219-7, Notice of Partial Small Business Set-Aside (June 2003) (15 U.S.C. 644).				
	[] (ii) Alternate I (Oct 1995) of 52.219-7.				
	[] (iii) Alternate II (Mar 2004) of 52.219-7.				
	[] (12) 52.219-8, Utilization of Small Business Concerns (May 2004) (15 U.S.C. 637(d)(2) and (3)).				
	[] (13) (i) 52.219-9, Small Business Subcontracting Plan (Apr 2008) (15 U.S.C. 637(d)(4)).				
	[] (ii) Alternate I (Oct 2001) of 52.219-9.				
	[] (iii) Alternate II (Oct 2001) of 52.219-9.				
	[] (14) 52.219-14, Limitations on Subcontracting (Dec 1996) (15 U.S.C. 637(a)(14)).				
	[] (15) 52.219-16, Liquidated Damages-Subcontracting Plan (Jan 1999) (15 U.S.C. 637(d)(4)(F)(i)).				
	[] (16) (i) 52.219-23, Notice of Price Evaluation Adjustment for Small Disadvantaged Business Concerns (OCT 2008) (10 U.S.C. 2323) (if the offeror elects to waive the adjustment, it shall so indicate in its offer).				
	[] (ii) Alternate I (June 2003) of 52.219-23.				
	[] (17) 52.219-25, Small Disadvantaged Business Participation Program-Disadvantaged Status and Reporting (Apr 2008) (Pub. L. 103-355, section 7102, and 10 U.S.C. 2323).				
	[] (18) 52.219-26, Small Disadvantaged Business Participation Program- Incentive Subcontracting (Oct 2000) (Pub. L. 103-355, section 7102, and 10 U.S.C. 2323).				
	[] (19) 52.219-27, Notice of Total Service-Disabled Veteran-Owned Small Business Set-Aside (May 2004) (15 U.S.C. 657 f).				
	[] (20) 52.219-28, Post Award Small Business Program Representation (Apr 2009) (15 U.S.C. 632(a)(2)).				
	[X] (21) 52.222-3, Convict Labor (June 2003) (E.O. 11755).				
	[X] (22) 52.222-19, Child Labor-Cooperation with Authorities and Remedies (Jul 2010) (E.O. 13126).				
	[X] (23) 52.222-21, Prohibition of Segregated Facilities (Feb 1999).				
	[X] (24) 52.222-26, Equal Opportunity (Mar 2007) (E.O. 1246).				
	[] (25) 52.222-35, Equal Opportunity for Special Disabled Veterans, Veterans of the Vietnam Era, and Other Eligible Veterans (Sept 2006) (38 U.S.C. 4212).				
	[] (26) 52.222-36, Affirmative Action for Workers with Disabilities (Jun 1998) (29 U.S.C. 793).				
	Continued ...				

CONTINUATION SHEET		REFERENCE NO. OF DOCUMENT BEING CONTINUED		PAGE	
		GS-10F-0098W/HHSF233201000693G		5 OF 20	
NAME OF OFFEROR OR CONTRACTOR					
KNOWLEDGE NETWORKS, INC. 1368146					
ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	[] (27) 52.222-37, Employment Reports on Special Disabled Veterans, Veterans of the Vietnam Era, and Other Eligible Veterans (Sept 2006) (38 U.S.C. 4212).				
	[] (28) 52.222-54, Employment Eligibility Verification (JAN 2009). (Executive Order 12989). (Not applicable to the acquisition of commercially available off-the-shelf items or certain other types of commercial items as prescribed in 22.1803.)				
	[] (29) (i) 52.223-9, Estimate of Percentage of Recovered Material Content for EPA Designated Items (May 2008) (42 U.S.C. 6962(c)(3)(A)(ii)). (Not applicable to the acquisition of commercially available off-the-shelf items.)				
	[] (ii) Alternate I (May 2008) of 52.223-9 (42 U.S.C. 6962(i)(2)(C)). (Not applicable to the acquisition of commercially available off-the-shelf items.)				
	[] (30) 52.223-15, Energy Efficiency in Energy-Consuming Products (DEC 2007). (42 U.S.C. 8259b).				
	[] (31) (i) 52.223-16, IEEE 1680 Standard for the Environmental Assessment of Personal Computer Products (DEC 2007) (E.O. 13423).				
	[] (ii) Alternate I (DEC 2007) of 52.223-16.				
	[] (32) 52.225-1, Buy American Act-Supplies (Feb 2009) (4 U.S.C. 10a-10d).				
	[] (33) (i) 52.225-3, Buy American Act-Free Trade Agreements-Israeli Trade Act (June 2009) (41 U.S.C. 10a-10d, 19 U.S.C. 3301 note, 19 U.S.C. 2112 note, 19 U.S.C. 3805 note, Pub. L. 108-77, 108-78, 108-286, 108-302, 109-53, 109-169, 109-283, and 110-138).				
	[] (ii) Alternate I (Jan 2004) of 52.225-3.				
	[] (iii) Alternate II (Jan 2004) of 52.225-3.				
	[] (34) 52.225-5, Trade Agreements (AUG 2009) (19 U.S.C. 2501, et seq., 19 U.S.C. 3301 note).				
	[x] (35) 52.225-13, Restrictions on Certain Foreign Purchases (June 2008) (E.O. 7s, proclamations, and statutes administered by the Office of Foreign Assets Control of the Department of the Treasury).				
	[] (36) 52.226-4, Notice of Disaster or Emergency Area Set-Aside (Nov 2007) (42 U.S.C. 5150).				
	[] (37) 52.226-5, Restrictions on Subcontracting Outside Disaster or Emergency Area (Nov 2007) (42 U.S.C. 5150).				
	[] (38) 52.232-29, Terms for Financing of Purchases of Commercial Items (Feb 2002) (41 U.S.C. 255(f), 10 U.S.C. 2307(f)).				
	[] (39) 52.232-30, Installment Payments for Commercial Items (Oct 1995) (41 U.S.C. 255(f), 10 U.S.C. 2307(f)).				
	[X] (40) 52.232-33, Payment by Electronic Funds Transfer-Central Contractor Registration (Oct 2003) (31 U.S.C. 3332).				
	[] (41) 52.232-34, Payment by Electronic Funds Transfer-Other than Central Contractor Registration (May 1999) (31 U.S.C. 3332).				
	[] (42) 52.232-36, Payment by Third Party (Feb 2010) (31 U.S.C. 3332).				
	[] (43) 52.239-1, Privacy or Security Safeguards (Aug 1995) (5 U.S.C. 552a).				
	[] (44) (i) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (Feb 2006) (46 U.S.C. Appx. 1241(b) and 10 U.S.C. 2631).				
	[] (ii) Alternate I (Apr 2003) of 52.247-64.				
	(c) The Contractor shall comply with the FAR clauses in this paragraph (c), applicable to commercial services, that the Contracting Officer has indicated as Continued ...				

CONTINUATION SHEET		REFERENCE NO. OF DOCUMENT BEING CONTINUED	PAGE	OF	
		SS-10F-0098W/HHSF233201000693G	6	20	
NAME OF OFFEROR OR CONTRACTOR					
KNOWLEDGE NETWORKS, INC. 1368146					
ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	being incorporated in this contract by reference to implement provisions of law or Executive orders applicable to acquisitions of commercial items: [Contracting Officer check as appropriate.] [] (1) 52.222-41, Service Contract Act of 1965 (Nov 2007) (41 U.S.C. 351, et seq.). [] (2) 52.222-42, Statement of Equivalent Rates for Federal Hires (May 1989) (29 U.S.C. 206 and 41 U.S.C. 351, et seq.). [] (3) 52.222-43, Fair Labor Standards Act and Service Contract Act-Price Adjustment (Multiple Year and Option Contracts) (Sep 2009) (29 U.S.C. 206 and 41 U.S.C. 351, et seq.). [] (4) 52.222-44, Fair Labor Standards Act and Service Contract Act-Price Adjustment (Sep 2009) (29 U.S.C. 206 and 41 U.S.C. 351, et seq.). [] (5) 52.222-51, Exemption from Application of the Service Contract Act to Contracts for Maintenance, Calibration, or Repair of Certain Equipment-Requirements (Nov 2007) (41 351, et seq.). [] (6) 52.222-53, Exemption from Application of the Service Contract Act to Contracts for Certain Services-Requirements (Feb 2009) (41 U.S.C. 351, et seq.). [] (7) 52.226-6, Promoting Excess Food Donation to Nonprofit Organizations (Mar 2009) (Pub. L. 110-247). [] (8) 52.237-11, Accepting and Dispensing of \$1 Coin (Sept 2008) (31 U.S.C. 5112(p)(1)). (d) Comptroller General Examination of Record. The Contractor shall comply with the provisions of this paragraph (d) if this contract was awarded using other than sealed bid, is in excess of the simplified acquisition threshold, and does not contain the clause at 52.215-2, Audit and Records-Negotiation. (1) The Comptroller General of the United States, or an authorized representative of the Comptroller General, shall have access to and right to examine any of the Contractor's directly pertinent records involving transactions related to this contract. (2) The Contractor shall make available at its offices at all reasonable times the records, materials, and other evidence for examination, audit, or reproduction, until 3 years after final payment under this contract or for any shorter period specified in FAR Subpart 4.7, Contractor Records Retention, or the other clauses of this contract. If this contract is completely or partially terminated, the records relating to the work terminated shall be made available for 3 years after any resulting final termination settlement. Records relating to: appeals under the disputes clause or to litigation or the settlement of claims arising under or relating to this contract shall be made available until such appeals, litigation, or claims are finally resolved. (3) As used in this clause, records include books, documents, accounting procedures and practices, and other data, regardless of type and regardless of form. This does not require the Contractor to create or maintain any record that the Contractor does not maintain in the ordinary course of business or pursuant to a provision of law. (e)(1) Notwithstanding the requirements of the clauses in paragraphs (a), (b), (c), and (d) of this clause, the Contractor is not required to flow down any FAR clause, other than those in this paragraph (e)(1) in a subcontract for commercial items. Unless otherwise indicated below, the extent of the flow down shall be as required Continued ...				

CONTINUATION SHEET		REFERENCE NO. OF DOCUMENT BEING CONTINUED		PAGE OF	
GS-10F-0098W/HHSF233201000693G				7 20	
NAME OF OFFEROR OR CONTRACTOR					
KNOWLEDGE NETWORKS, INC. 1368146					

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	<p>by the clause-</p> <p>(i) 52.203-13, Contractor Code of Business Ethics and Conduct (Apr 2010) (Pub. L. 110-252, Title VI, Chapter 1 (41 U.S.C. 251 note)).</p> <p>(ii) 52.219-8, Utilization of Small Business Concerns (May 2004) (15 U.S.C. 637(d)(2) and (3)), in all subcontracts that offer further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds \$550,000 (\$1,000,000 for construction of any public facility), the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.</p> <p>(iii) [Reserved]</p> <p>(iv) 52.222-26, Equal Opportunity (Mar 2007) (E.O. 11246).</p> <p>(v) 52.222-35, Equal Opportunity for Special Disabled Veterans, Veterans of the Vietnam Era, and Other Eligible Veterans (Sept 2006) (38 U.S.C. 4212).</p> <p>(vi) 52.222-36, Affirmative Action for Workers with Disabilities (June 1998) (29 U.S.C. 793).</p> <p>(vii) [Reserved]</p> <p>(viii) 52.222-41, Service Contract Act of 1965 (Nov 2007) (41 U.S.C. 351, et seq.).</p> <p>(ix) 52.222-50, Combating Trafficking in Persons (Feb 2009) (22 U.S.C. 7104(g)).</p> <p>[] Alternate I (Aug 2007) of 52.222-50 (22 U.S.C. 7104(g)).</p> <p>(x) 52.222-51, Exemption from Application of the Service Contract Act to Contracts for Maintenance, Calibration, or Repair of Certain Equipment-Requirements (Nov 2007) (41 U.S.C. 351, et seq.).</p> <p>(xi) 52.222-53, Exemption from Application of the Service Contract Act to Contracts for Certain Services-Requirements (Feb 2009) (41 U.S.C. 351, et seq.).</p> <p>(xii) 52.222-54, Employment Eligibility Verification (JAN 2009).</p> <p>(xiii) 52.226-6, Promoting Excess Food Donation to Nonprofit Organizations (Mar 2009) (Pub. L. 110-247). Flow down required in accordance with paragraph (e) of FAR clause 52.226-6.</p> <p>(xiv) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (Feb 2006) (46 U.S.C. Appx. 1241(b) and 10 U.S.C. 2631). Flowdown required in accordance with paragraph (d) of FAR clause 52.247-64.</p> <p>(2) While not required, the contractor may include in its subcontracts for commercial items a minimal number of additional clauses necessary to satisfy its contractual obligations.</p> <p>All other applicable clauses from the base Contract GS-10F-0098W remain in full force and effect.</p>				

HHS 7540-01-152-8087

OPTIONAL FORM 330 (4-86)
Sponsored by GSA
FAR (48 CFR) 51.115

SECTION A: STATEMENT OF WORK

1.0 TITLE

Survey on Long-Term Care Awareness and Planning

1.1 PURPOSE

The purpose is to collect questionnaire responses from a sample of the American public about their attitudes, experiences, opinions and actions related to long-term care services. This will be accomplished by using Knowledge Networks' nationwide online panel (KnowledgePanel) as a platform for fielding interactive chats, online town hall meetings, and an online questionnaire. This is one of three inter-related

task orders intended to assist in the implementation of provisions of the Affordable Care Act (ACA) related to long-term care financing and awareness. Development of the questionnaire, and the OMB clearance package, and analysis of the data will be completed by two other contractors through related task orders.

1.2 BACKGROUND

Successful implementation of the new ACA provisions will require a well-developed understanding of how the American public assesses their possible future need for long-term care. The ACA includes the development of a new voluntary insurance program for long-term care as well as a national awareness campaign. In order to obtain sufficient enrollment in the new insurance program, consumer preferences will need to be understood and to some extent accommodated. Results from these task orders will be used to develop educational and marketing materials as well as to inform the design of the insurance program.

Knowledge Networks has been selected for the project based on their national, probability-based survey panel. The panel was constructed using dual-frame sample recruitment that includes both random digit dialing and address-based sampling. Knowledge Networks panel provides a statistically valid representation of the American public and includes many difficult to reach populations.

Using Knowledge Networks is a less costly method for obtaining consumer input than other survey methods. This method has several advantages for this particular data collection effort as follows:

- all responses are gathered on-line, reducing both administrative costs and the amount of time necessary to collect the data;
- respondents that do not have computers or internet access are provided these as a part of their participation agreement;
- using a proprietary panel (that uses address and phone-based sampling) avoids the problem of reaching the increasing share of the population without a telephone land line; and,
- extensive demographic and socio-economic data have already been collected on the entire sample allowing questionnaires to focus solely on areas of interest.

In addition, Knowledge Network offers the opportunity to gather consumer input in a variety of forms including small interactive chats that resemble focus groups, online town hall meetings and questionnaire responses from a national sample of adults. The use of a variety of methods to collect consumer input through one contract vehicle allows for a more effective and flexible collection of data that can change as conditions or requirements change.

The contractor for this project must be willing to coordinate with the contractors selected for the task orders entitled “Development of a Survey on Long-Term Care Awareness and Planning” and “Development and Testing of Long-Term Care Awareness Materials.” It is anticipated that each of the three contractors will designate a liaison that will be responsible for coordinating with the other contractors.

1.3 SPECIFIC TASKS

Task 1.0 Post-Award Logistics

Subtask 1.1: Post-Award Meeting

Within two (2) weeks of award, staff from Knowledge NetWorks and other relevant staff (including the liaisons for the other task orders) shall meet with the ASPE task order officers to discuss the objectives of the contract and any related project issues. The Government anticipates a joint post-award meeting for all three task orders. Specific topics to be discussed include, but are not limited to: the objectives of the project, major deliverables, work schedule, questionnaire testing, and contract coordination.

Subtask 1.2: Work Plan

Knowledge Networks shall develop a work plan that will guide the activities of the project. The work plan, which will reflect the results of the post-award meeting (Sub-task 1.1), will serve as a blueprint for their approach to carrying out project activities and specific timelines for the project tasks. The draft work plan will include a process for communicating with the other task order liaisons. The draft work plan shall be submitted to the task order officers for review two (2) weeks after the post-award meeting. The work plan shall be considered final upon approval of the task order officers.

Task 2.0 Interactive Chats

Knowledge Networks shall convene three sets of interactive chats featuring moderated on-line discussions and manage all logistics and chat technologies. Each chat will feature informal, moderated, online discussions during which consumers will be offered the opportunity to respond to prototype educational/marketing materials. The number of chats will be determined as a result of work on a preliminary market segmentation framework completed under a separate task order. For budget purposes, the contractor should assume three (3) sets of chats. Each set will consist of chats with three (3) distinct groups, each with no more than nine (9) participants for a grand total of nine (9) chats with 81 total participants. Respondents will be selected based on the preliminary market segmentation framework. The task order officers will approve the final selection of the chat participants within each market segment as described in the framework.

Knowledge Networks shall provide prototype awareness materials (also developed in a separate contract) to each participant. The materials will be the subject of a facilitated discussion that allows each chat participant to offer their own written and/or verbal comments and see the written and/or verbal responses of other participants. Participants will be asked to comment on any aspect of the materials. Knowledge Networks will provide a technical moderator for the chat. A content moderator representing another ASPE contractor shall moderate the sessions and stimulate conversation as necessary. Knowledge Networks shall keep a record of the comments offered during the sessions. Knowledge Networks shall also provide technical assistance to the task order officers to help facilitate the interactive chats in an on-line fashion. The timing of the chats is as follows:

Sub-Task 2.1: First Set

Knowledge Networks, in conjunction with the ASPE task order officers, will determine the timing of the first set of interactive chats. The government anticipates it will take place no more than thirty-six (36) weeks from contract award. A record of the online session shall be provided to the task order officers no later than 2 weeks after completion of the chat.

Sub-Task 2.2: Second Set

Knowledge Networks, in conjunction with the ASPE task order officers, will determine the timing of the second set of interactive chats. The government anticipates it will take place no more than forty-two (42) weeks from contract award. A record of the online session shall be provided to the task order officers no later than 2 weeks after completion of the chat.

Sub-Task 2.3: Third Set

Knowledge Networks, in conjunction with the ASPE task order officers, will determine the timing of the third set of interactive chats. The government anticipates it will take place no more than forty-eight (48) weeks from contract award. A record of the online session shall be provided to the task order officers no later than 2 weeks after completion of the chat.

Task 3.0 Online Town Hall Meetings

Knowledge Networks shall convene six online town hall meetings. The town hall meetings will feature a presentation by a moderator (provided through a separate contract) followed by informal discussions and instant polling of participants.

Participants will be offered the opportunity to respond to prototype educational/marketing materials, to raise questions and to offer responses to instant polls. Each town hall meeting will consist of no more than 100 participants. Respondents will be selected based on the preliminary market segmentation framework. The task order officers will work with Knowledge Networks to align the selection of the participants with each market segment. Knowledge Networks shall provide a technical moderator to manage all technical aspects of the meetings. Knowledge Networks shall provide prototype awareness materials (provided by the task order officers) to each meeting participant.

The government anticipates that the online town hall meetings shall be convened between 50–70 weeks after award of the contract. The task order officers shall work with Knowledge Networks on the scheduling of the meetings. A record of the town hall meetings shall be provided to the task order officers no later than 2 weeks after completion of each meeting.

Task 4.0 Attitudes and Opinions Questionnaire

Sub-Task 4.1: Pretest

Knowledge Networks shall arrange for a questionnaire pretest with no more than 25 cases. This pretest will allow for examining questionnaire length, possible coding or respondent answering problems and for testing response data delivery. Data from the pretest shall be provided to the government. The pretest shall be completed no later than sixty (60) weeks after contract award.

Sub-Task 4.2: Data Collection

Knowledge Networks shall invite panel participants between the ages of 40 and 70 to respond to the questionnaire. The sample shall be large enough to obtain 18,000 responses. The government anticipates that the questionnaire will take 40 minutes to complete. Knowledge Networks will inform the task order officers of any problems that arise during data collection. Collection of data shall occur within eighty (80) weeks after contract award.

Sub-Task 4.3: Data Delivery

Questionnaire response data shall be provided to the task order officers and the ASPE contractor no later than eighty-four (84) weeks after contract award. These files should at least be delivered as flat ASCII files and preferably as SAS data files.

Task 5.0 Evaluation Processes Memo

Knowledge Networks shall provide a short memo that discusses the administration of the interactive discussions and questionnaire in the above tasks (Tasks 2–4). The purpose of the memo is to describe issues or problems that should be taken into consideration when analyzing the data. Of particular concern are issues that arose in the testing of consumer materials. Knowledge Networks shall note any logistical problems or other limitations in the data to be used for this purpose. The memo shall be delivered to the ASPE task order officers within eighty-four (84) weeks of contract award.

2.0 PERIOD OF PERFORMANCE/DELIVERABLES**2.1 PERIOD OF PERFORMANCE**

The period of performance shall be 86 weeks from the date of award.

2.2 PLACE OF PERFORMANCE

All work performed under this task order shall be accomplished at the Contractor's facility.

2.3 DELIVERABLE SCHEDULE

The Contractor shall deliver the following items in accordance with the schedule set forth below:

Task	Deliverable	Date Due	# of Copies to T00
Task 1	Post-Award Logistics		
	1: Post-Award Meeting	Week 2.	1 electronically
	1.2: Work Plan	Week 4	1 electronically
Task 2	Interactive Chats		
	2.1: First Set	Week 36.	1 electronically
	2.2: Second Set	Week 42	1 electronically
	2.3: Third Set	Week 48	1 electronically
Task 3	Town Hall Meetings	Weeks 50–70	1 electronically
Task 4	Survey of Attitudes and Opinions		
	4.1: Pretest	Week 60.	1 electronically
	4.2: Data Collection	Week 80	1 electronically
	4.3: Data Delivery	Week 84	1 electronically
Task 5	Evaluation Processes Memo	Weeks 86	1 electronically

2.4 PERFORMANCE REQUIREMENTS

The Performance Requirements Summary (PRS) below lists requirements that the Government will evaluate. The absence of any task order requirement from the PRS shall not detract from its enforceability nor limit the rights or remedies of the Government under any other provision of the task order, including the clauses entitled “Inspection of Services” and “Default.”

Required Services/ Tasks	Performance Standards	Method of Surveillance (Quality of Assurance)	Standard to be Met/ Allowable Deviation	Deduction
Customer satisfaction.	Contractor adheres to guidance provided by task order, officer.	Task order officer will work closely with contractor.	Contractor provides consumer response data to task order officers in a timely fashion.	Up to 2 percent of fixed fee.
Task 3—Center-Active Chats.	Contractor successfully recruits sufficient number of participants for inter-active chats and ensures smooth operation of communication technology.	Task order officers will participate in all chats.	Each chat must have at least nine participants. Operation of technology must not present an obstacle to obtaining consumer input.	Up to 1 percent of fixed fee.
Task 4—Town Hall Meetings.	Contractor will recruit sufficient number of participants for each town hall meeting and ensure smooth operation of communication technology.	Task order officer will participate in each town hall meeting.	Each town hall meeting should have at least 80 participants. Operation of communications technology must not present an obstacle to obtaining consumer input.	Up to 2 percent of fixed fee.
Task 5—Questionnaire.	Contractor will recruit a sufficient sample of panel members to obtain desired number of questionnaire responses and data is submitted in a timely fashion.	Task order officers will work closely with contractor.	Questionnaire response data should be provided to the task order officers not later than 3 weeks after questionnaire responses have been submitted.	Up to 2 percent of fixed fee.

3.0 GOVERNMENT FURNISHED PROPERTY/INFORMATION

3.1 GOVERNMENT FURNISHED PROPERTY/INFORMATION

The government will provide:

- prototype educational/marketing materials to be tested; and,
- an OMB approved questionnaire

4.0 TASK ORDER ADMINISTRATION DATA

4.1 AUTHORIZATION OF GOVERNMENT PERSONNEL

Notwithstanding the Contractor’s responsibility for total management during the performance of this task order, the administration of the Task order will require maximum coordination between the Government and the Contractor. The following individuals will be the Government’s points of contact during the performance of this task order:

1. Contract Specialist

All order administration shall be performed by:

Kevin McGowan
Contract Specialist
Division of Acquisition Management
Parklawn Building, Room 5–101

5600 Fishers Lane
 Rockville, MD 20857
 (301) 443-0708
 Kevin.McGowan@psc.hhs.gov

2. Contracting Officer

The PSC Contracting Officer is the only individual authorized to modify this order. The Contracting Officer responsible for administrative and contractual issues concerning this task order is:

(To be determined upon award.)

3. Contracting Officers' Technical Representative Appointment and Authority

The name and address of the COTR assigned to this project is:

(To be determined upon award.)

(a) Performance of work under this task order must be subject to the technical direction of the Contracting Officers' Technical Representative identified above, or a representative designated in writing. The term "technical direction" includes, without limitation, direction to the contractor that directs or redirects the labor effort, shifts the work between work areas or locations, fills in details and otherwise serves to ensure that tasks outlined in the work statement are accomplished satisfactorily.

(b) Technical direction must be within the scope of the specification(s)/work statement.

The Contracting Officers' Technical Representative does not have authority to issue technical direction that:

(1) Constitutes a change of assignment or additional work outside the specification(s)/statement of work;

(2) Constitutes a change as defined in the clause entitled "Changes";

(3) In any manner causes an increase or decrease in the task order price, or the time required for task order performance;

(4) Changes any of the terms, conditions, or specification(s)/work statement of the task order;

(5) Interferes with the Contractor's right to perform under the terms and conditions of the task order; or

(6) Directs, supervises or otherwise controls the actions of the contractor's employees.

(c) Technical direction may be oral or in writing. The Contracting Officers' Technical Representative shall confirm oral direction in writing within 5 work days, with a copy to the Contracting Officer.

(d) The contractor shall proceed promptly with performance resulting from the technical direction issued by the Contracting Officers' Technical Representative. If, in the opinion of the contractor, any direction of the Contracting Officers' Technical Representative, or his/her designee, falls within the limitations in (c), above, the contractor shall immediately notify the Contracting Officer no later than the beginning of the next Government work day.

(e) Failure of the contractor and the Contracting Officer to agree that technical direction is within the scope of the task order shall be subject to the terms of the clause entitled "Disputes."

4.2 HHSAR 352.242-70 KEY PERSONNEL (JAN 2006)

The key personnel specified in this task order are considered to be essential to work performance. At least 30 days prior to diverting any of the specified individuals to other programs or contracts (or as soon as possible, if an individual must be replaced, for example, as a result of leaving the employ of the Contractor), the Contractor shall notify the Contracting Officer and shall submit comprehensive justification for the diversion or replacement request (including proposed substitutions for key personnel) to permit evaluation by the Government of the impact on performance under this task order. The Contractor shall not divert or otherwise replace any key personnel without the written consent of the Contracting Officer. The Government may modify the task order to add or delete key personnel at the request of the Contractor or Government.

(End of clause)

The individuals cited below are key personnel:

Name _____ Title _____
 (To be entered upon award.)

4.3 INVOICE SUBMISSION

1. The Contractor shall submit one original monthly invoice complete with all required back-up documentation to the Contract Specialist, Kevin McGowan, at *Kevin.McGowan@psc.hhs.gov* or sent by U.S. mail and addressed as follows:

DHHS/Program Support Center
 Division of Acquisition Management
 Attn: Matthew Gormley
 Parklawn Building, Room 5-101
 Rockville, MD 20857

One complete copy of each invoice with backup documentation shall be emailed to the COTR.

Three hard copies of all invoices with all required back-up documentation shall be sent directly to the Finance Office for payment or an electronic copy of all invoices with all back-up documentation may be e-mailed to *psc_invoices@psc.hhs.gov*. It is the responsibility of the Contractor to verify that the Finance Office has received their invoice. Calls concerning contract payment shall be directed to the general help-line number on (301) 443-6766. The address for the Finance Office responsible for payment is:

DHHS/Program Support Center
 Financial Management Services/DFO
 Commercial Payments Section
 Parklawn Building, Room 16A-12
 5600 Fishers Lane
 Rockville, MD 20857
 Telephone Number: 301-443-6766

2. The Contractor agrees to include the following information on its invoice:

- Contractor's name, invoice number and date;
- Contract Number and Task Order Number;
- Employee name and title (labor category); the loaded hourly rate; number of hours used during the month; number of hours remaining for the task order period; dollar amount billed for the month; cumulative dollar amount billed to date for the task order period; the balance remaining for the task order period;
- Payment terms;
- Tax identification number;
- Signature of an authorized official certifying the voucher to be correct and proper for payment;
- Contractor's complete remittance or check mailing address; and
- COTR's name and telephone number.

5.0 OBSERVANCE OF FEDERAL HOLIDAYS

No services or deliveries shall be performed on Federal property on Saturdays, Sundays or Federal legal holidays as shown below:

Government holidays are:

- 1 New Year's Day—January 1st
2. Martin Luther King's Birthday—Third Monday in January
3. President's Day—Third Monday in February
4. Memorial Day—Last Monday in May
5. Independence Day—July 4th
6. Labor Day—First Monday in September
7. Columbus Day—Second Monday in October
8. Veteran's Day—November 11th
9. Thanksgiving Day—Fourth Thursday in November
10. Christmas Day—December 25th

6.0 TASK ORDER TYPE

The Government anticipates award of a Firm Fixed Price Task Order.

Note: Cancellation costs will not be incorporated into this Non-Severable Task Order.

7.0 SPECIAL TASK ORDER REQUIREMENTS

7.1 HHS Section 508 Accessibility Standards Notice (September 2009)

Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d) requires Federal agencies to purchase electronic and information technologies (EIT) that meet specific accessibility standards. This law helps to ensure that Federal employees with disabilities have access to, and use of, the information and data they need to do their jobs. Furthermore, this law ensures that members of the public with disabilities have the ability to access government information and services.

There are three regulations addressing the requirements detailed in Section 508. The Section 508 technical and functional standards are codified at 36 CFR Part 1194 and may be accessed through the Access Board's Web site at <http://www.access-board.gov>. The second regulation issued to implement Section 508 is the Federal Acquisition Regulation (FAR). FAR Part 39.2 requires that agency acquisitions of Electronic and Information Technology (EIT) comply with the Access Board's standards. The entire FAR is found at Chapter 1 of the Code of Federal Register (CFR) Title 48, located at <http://www.acquisition.gov>. The FAR rule implementing Section 508 can be found at <http://www.section508.gov>. The third applicable regulation is the HHS Acquisition Regulation (HHSAR).

Regardless of format, all Web content or communications materials produced for publication on or delivery via HHS Web sites—including text, audio or video—must conform to applicable Section 508 standards to allow Federal employees and members of the public with disabilities to access information that is comparable to information provided to persons without disabilities. All contractors (including sub-contractors) or consultants responsible for preparing or posting content intended for use on an HHS-funded or HHS-managed Web site must comply with applicable Section 508 accessibility standards, and where applicable, those set forth in the referenced policy or standards documents below. Remediation of any materials that do not comply with the applicable provisions of 36 CFR Part 1194 as set forth in the SOW or PWS, shall be the responsibility of the contractor or consultant retained to produce the Web-suitable content or communications material.

The following Section 508 provisions apply to the content or communications material identified in this SOW—PWS: Access Board Final Rule 36 CFR Part 1194.22(a)–(p).

7.2 Requirements Regarding Permission to Disclose or Publish Findings Prior to Delivery Order End Date

The contractor and any consultants or subcontractors agree not to release or disclose, verbally or in writing, information pertaining to the results or findings of work (including data collection, analyses, draft or final papers and reports) for the period of this delivery order without obtaining prior written approval of the Task Order Officer. The contractor must request approval in advance (minimum 21 days prior to release) and in writing, specifying: who or what is generating the request for advance information; when and how project results/information will be released; and what information would be released. Failure to receive response from the Task Order Officer does not constitute approval for releasing information.

7.3 Food And Beverage—Unallowable Costs

Food and beverage costs, unless part of per diem expenses paid in accordance with the Federal Travel Regulations, are unallowable costs to this task order.

7.4 Contractor Performance Evaluation

During the life of this order, the Contractor's performance will be evaluated on an interim and final basis pursuant to FAR Subpart 42.15. The evaluation will be conducted utilizing the National Institutes of Health Contractor Performance System (CPS). The Contractor shall register in the CPS. The CPS may be accessed by the Contractor at <https://cpsContractor.nih.gov>.

7.5 Travel

The Contractor will be reimbursed for travel to provide support at a Government site or other site as may be specified and approved by the COTR under this effort. All travel shall be approved, by the COTR, prior to commencement of travel. The contractor shall be reimbursed for actual allowable, allocable, and reasonable travel costs incurred during performance of this effort in accordance with the Federal Travel Regulations in effect on date of travel.

The Contractor shall provide supporting documentation and a detailed breakdown of incurred travel costs with each invoice.

8.0 CONTRACT CLAUSES/PROVISIONS

In addition to applicable terms and conditions of the Offeror's GSA MOBIS contract, the following Federal Acquisition Regulation and Health & Human Services Acquisition Regulation Provisions/Clauses apply to this acquisition:

HHSAR 352.239-73 Electronic Information Technology Accessibility (Oct 2009)

(a) Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d), as amended by the Workforce Investment Act of 1998, and the Architectural and Transportation Barriers Compliance Board Electronic and Information (EIT) Accessibility Standards (36 CFR Part 1194), require that, unless an exception applies, all EIT products and services developed, acquired, maintained, or used by any Federal department or agency permit—

(1) Federal employees with disabilities to have access to and use information and data that is comparable to the access and use of information and data by Federal employees who are not individuals with disabilities; and

(2) Members of the public with disabilities seeking information or services from a Federal agency to have access to and use of information and data that is comparable to the access and use of information and data by members of the public who are not individuals with disabilities.

(b) Accordingly, any vendor submitting a proposal/quotation/bid in response to this solicitation must demonstrate compliance with the established EIT accessibility standards. Information about Section 508 is available at www.section508.gov. The complete text of Section 508 Final Provisions can be accessed at www.access-board.gov/sec508/provisions.

(c) The Section 508 accessibility standards applicable to this solicitation are identified in the Statement of Work/Specification/Performance Work Statement. In order to facilitate the Government's evaluation to determine whether EIT products and services proposed meet applicable Section 508 accessibility standards, offerors must prepare an HHS Section 508 Product Assessment Template, in accordance with its completion instructions, and provide a binding statement of conformance. The purpose of the template is to assist HHS acquisition and program officials in determining that EIT products and services proposed support applicable Section 508 accessibility standards. The template allows vendors or developers to self-evaluate their products or services and document in detail how they do or do not conform to a specific Section 508 accessibility standard. Instructions for preparing the HHS Section 508 Evaluation Template may be found under Section 508 policy on the HHS Office on Disability Web site www.hhs.gov/od.

(d) Respondents to this solicitation must also provide any additional detailed information necessary for determining applicable Section 508 accessibility standards conformance, as well as for documenting EIT products or services that are incidental to the project, which would constitute an exception to Section 508 requirements. If a vendor claims its products or services, including EIT deliverables such as electronic documents and reports, meet applicable Section 508 accessibility standards in its completed HHS Section 508 Product Assessment Template, and it is later determined by the Government—i.e., after award of a contract/order; that products or services delivered do not conform to the described accessibility standards in the Product Assessment Template, remediation of the products or services to the level of conformance specified in the vendor's Product Assessment Template will be the responsibility of the Contractor and at its expense. (end of provision)

FAR 52.252-2 Clauses Incorporated by Reference (FEB 1998)

This task order incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, a full text of a clause may be accessed electronically at these addresses: FAR—<http://www.acqnet.gov/far> and HHSAR—<http://www.hhs.gov/oamp/policies/hssar.doc>.

a. FEDERAL ACQUISITION REGULATION (FAR) (48 CFR CHAPTER 1) CONTRACT CLAUSES

FAR Clause No.	Title and Date
1. 52.204-7	Central Contractor Registration (Apr 2008)

FAR Clause No.	Title and Date
2. 52.212-4	Contract Terms And Conditions—Commercial Items (Mar 2009), Alternate I (Oct 2008)
3. 52.227-14	Rights In Data—General (Dec 2007)

SOLICITATION/CONTRACT ORDER FOR COMMERCIAL ITEM		1. REQUISITION NUMBER OS42263		PAGE OF 1 20	
2. CONTRACT NO. HHSP23320100022W1		3. AWARD EFFECTIVE DATE 09/30/2010		4. ORDER NUMBER HHSP23337001T	
7. FOR SOLICITATION INFORMATION CALL:		8. NAME WENDY CRUZ		9. TELEPHONE NUMBER (No collect calls) 301-443-3086	
8. ISSUED BY DHHS/PSC/SAS/DAM Parklawn Building, Room 5C-18 5600 Fishers Lane MD Rockville 20857		10. THIS ACQUISITION IS <input checked="" type="checkbox"/> UNRESTRICTED OR <input type="checkbox"/> SET ASIDE: % FOR: <input type="checkbox"/> SMALL BUSINESS <input type="checkbox"/> EMERGING SMALL BUSINESS <input type="checkbox"/> HUBZONE SMALL BUSINESS <input type="checkbox"/> SOLE SOURCE NAICS: 541611 SIZE STANDARD: \$7.0 <input type="checkbox"/> SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS <input type="checkbox"/> N/A		11. DELIVERY FOR FOR DESTINATION UNLESS BLOCK IS MARKED <input type="checkbox"/> SEE SCHEDULE	
12. DISCOUNT TERMS		13. THIS CONTRACT IS A RATED ORDER UNDER DPAS (15 CFR 750)		13a. RATING	
14. DELIVER TO OS Office of the Secretary 200 Independence Ave. S.W. Washington DC 20201		15. ADMINISTERED BY DHHS/PSC/SAS/DAM Parklawn Bldg., Room 5C-18 5600 Fishers Lane MD Rockville 20857		14. METHOD OF SOLICITATION <input type="checkbox"/> RFQ <input type="checkbox"/> IFB <input type="checkbox"/> RFP	
17a. CONTRACTOR/ OFFEROR THOMSON REUTERS (HEALTHCARE) INC 122581 777 E EISENHOWER PKWY MI ANN ARBOR 481063273		16a. PAYMENT WILL BE MADE BY FMS 5600 FISHERS LANE PARKLAWN BUILDING ROOM 16A-12 ROCKVILLE MD 20857		17b. CHECK IF REMITTANCE IS DIFFERENT AND PUT SUCH ADDRESS IN OFFER	
18. SUBMIT INVOICES TO ADDRESS SHOWN IN BLOCK 18a UNLESS BLOCK BELOW IS CHECKED		19. CHECKED		20. CHECKED	
19. ITEM NO.		20. SCHEDULE OF SUPPLIES/SERVICES		21. QUANTITY	
22. UNIT		23. UNIT PRICE		24. AMOUNT	
Tax ID Number: 06-1467923 DUNS Number: 036838092 Contractor shall provide the following support services in accordance with the attached Statement of Work and the contractors business and technical quote submitted September 9, 2010. The contractors technical and business quote dated September 9, 2010 are incorporated by reference. Appr. Yr.: 2010 CAN: 1999AS9 Object Class: 25106 Period of Performance: 09/30/2010 to 06/29/2012 Continued ... (Use Reverse and/or Attach Additional Sheets as Necessary)					
25. ACCOUNTING AND APPROPRIATION DATA 2010-1999AS9-25106		26. TOTAL AWARD AMOUNT (For Govt. Use Only) \$495,168.00			
27a. SOLICITATION INCORPORATES BY REFERENCE FAR 52.212-1, 52.212-4, FAR 52.212-3 AND 52.212-5 ARE ATTACHED. ADDENDUM <input type="checkbox"/> ARE <input type="checkbox"/> ARE NOT ATTACHED.		27b. CONTRACT PURCHASE ORDER INCORPORATES BY REFERENCE FAR 52.212-4, FAR 52.212-5 ARE ATTACHED. ADDENDUM <input type="checkbox"/> ARE <input checked="" type="checkbox"/> ARE NOT ATTACHED.			
28. CONTRACTOR IS REQUIRED TO SIGN THIS DOCUMENT AND RETURN COPIES TO ISSUING OFFICE. CONTRACTOR AGREES TO FURNISH AND DELIVER ALL ITEMS SET FORTH OR OTHERWISE IDENTIFIED ABOVE AND ON ANY ADDITIONAL SHEETS SUBJECT TO THE TERMS AND CONDITIONS SPECIFIED HEREIN.		29. AWARD OF CONTRACT REF. DATED YOUR OFFER ON SOLICITATION (BLOCK 6), INCLUDING ANY ADDITIONS OR CHANGES WHICH ARE SET FORTH HEREIN, IS ACCEPTED AS TO ITEMS.			
30a. SIGNATURE OF CONTRACTOR		31a. UNITED STATES OF AMERICA (SIGNATURE OF CONTRACTING OFFICER)			
30b. NAME AND TITLE OF SIGNER (Type or print) Jonathan S. Neunel Executive Vice President		31b. NAME OF CONTRACTING OFFICER (Type or print) CHRIS ATKINS		31c. DATE SIGNED 9/30/10	

19. ITEM NO.	20. SCHEDULE OF SUPPLIES/SERVICES	21. QUANTITY	22. UNIT	23. UNIT PRICE	24. AMOUNT
1	Development and Testing of Long-Term Care Awareness Materials				495,168.00

32a. QUANTITY IN COLUMN 21 HAS BEEN
☐ RECEIVED ☐ INSPECTED ☐ NOTED: ACCEPTED, AND CONFORMS TO THE CONTRACT, EXCEPT AS

32b. SIGNATURE OF AUTHORIZED GOVERNMENT REPRESENTATIVE 32c. DATE 32d. PRINTED NAME AND TITLE OF AUTHORIZED GOVERNMENT REPRESENTATIVE

32e. MAILING ADDRESS OF AUTHORIZED GOVERNMENT REPRESENTATIVE 32f. TELEPHONE NUMBER OF AUTHORIZED GOVERNMENT REPRESENTATIVE

32g. E-MAIL OF AUTHORIZED GOVERNMENT REPRESENTATIVE

33. SHIP NUMBER 34. VOUCHER NUMBER 35. AMOUNT VERIFIED CORRECT FOR 36. PAYMENT 37. CHECK NUMBER

☐ PARTIAL ☐ FINAL ☐ COMPLETE ☐ PARTIAL ☐ FINAL

38. S/R ACCOUNT NUMBER 39. S/R VOUCHER NUMBER 40. PAID BY

41a. I CERTIFY THIS ACCOUNT IS CORRECT AND PROPER FOR PAYMENT 41b. SIGNATURE AND TITLE OF CERTIFYING OFFICER 41c. DATE 42a. RECEIVED BY (Print) 42b. RECEIVED AT (Location) 42c. DATE RECD (YYMMDD) 42d. TOTAL CONTAINERS

STANDARD FORM 1400 (REV. 3/2004) BACK

Contract Number: HHSP23320100022WI
 Task Order Number: HHSP23337001T

SECTION C. STATEMENT OF WORK

Title

Development and Testing of Long-term Care Awareness Materials

I. Purpose

This task order is one of three inter-related task orders intended to assist in the implementation of provisions of the Affordable Care Act (ACA) related to long-term care financing and awareness. The two related task orders are: (1) Development of a Survey on Long-Term Care Awareness and Planning and (2) Survey of Long-Term Care Awareness and Planning.

The purpose of this task order is to develop a set of consumer-oriented long-term care awareness materials. The Department's current set of materials, designed as part of the National Clearinghouse for Long-Term Care Information (Clearing-

house), targets a broad 20-year (50–70) age bracket. The new materials will focus on different segments of the population in an effort to increase the salience of the materials. Also, the current materials were developed and tested nearly 10 years ago. A number of changes are necessary to bring them up to date with current planning options as well as changes in the relative level of long-term care awareness. The new materials are intended for use in a variety of Clearinghouse initiatives including educating consumers about a new Federal long-term care insurance program. This task order is limited to: (a) identifying this relevant target market (i.e., segments of the population), (b) analysis of consumer responses, and, (c) revision and design of the educational materials. The logistics for the interactive discussions will be coordinated by Knowledge Networks in a separate contract.

II. Background

Approximately 70 percent of Americans 65 years of age can expect to experience some level of long-term care need before they die.¹ Long-term care refers to a wide variety of services and supports used by persons who are unable to perform activities of daily living, such as bathing or dressing, because of a disability. Such services can be provided informally, by family members or neighbors, or through a network of formal long-term care service providers. However, the vast majority of such care is provided by informal (unpaid) caregivers. Over 78 percent of persons receiving long-term care rely solely on some form of informal care while 8 percent rely solely on formal, or paid, care.² For those without informal caregivers, or for those whose needs cannot be met by informal caregivers alone, there are a variety of formal long-term care service providers.

The type of formal long-term care with which consumers are most familiar is nursing home care. Approximately 35 percent of those using long-term care services will use some nursing home care, and 5 percent of long-term care users spend more than 5 years in such a facility.³ Increasingly, consumers are voicing a preference for remaining in their home for as long as possible. For some time, public policy at both the State and Federal levels has been moving towards expanding community-based options for persons needing long-term care.⁴

Long-term care services are expensive. A semi-private room in a nursing home costs an average of \$191 a day and home care services cost an average of \$20 an hour in 2008.⁵ The onset of chronic illness and the associated need for long-term care services can threaten the security of retirement finances. Johnson, et al. found that the onset of disability presented “a special financing challenge” for older adults. They estimate that spells of nursing home use can reduce household wealth by 60 percent for unmarried women.⁶

In spite of the number of people who will need such care and the significant threat to retirement finances that the high costs of care represent, most Americans are unaware of how much long-term care costs or who routinely pays for such services. In numerous surveys conducted over the last 10 years, a majority of respondents were unable to correctly identify who pays for long-term care or to correctly estimate the cost of such services. One of the most misunderstood aspects of long-term care financing is the role of Medicare. Several surveys report that more than half of pre-retiree respondents think that Medicare pays for custodial long-term care.^{7,8} Other studies assume that private health insurance or other public programs will pay.^{9,10}

¹ Kemper, Komisar, Alexih. *Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?* Inquiry—Excellus Health Plans; Winter 2005/2006; 42, 4

² Lee, Thompson. *Long-term Care: Support for Family Caregivers*. Long-Term Care Financing Project Issue Brief March 2004; Georgetown University.

³ Kemper, et al. 343.

⁴ Shirk, Cynthia. *Trading Places: Real Choice Systems Change Grants and the Movement to Community-Based Long-Term Supports* Issue Brief National Health Policy Forum No. 822, May 2007.

⁵ MetLife Mature Market Institute. *MetLife Market Survey of Nursing Home and Assisted Living Costs*. October 2008.

⁶ Johnson, Mermin, Uccello. *When the Nest Egg Cracks: Financial Consequences of Health Problems, Marital Status Changes, and Job Layoffs at Older Ages*.

⁷ Lake Research Partnership and American Viewpoint. *Survey of California Voters 40 and Older on Long-Term Care*. April 2010.

⁸ Mathematica Policy Research, Inc. *Shoring Up the Infrastructure for Long-Term Care: What Do Vulnerable Adults Know About Their Options*. Issue Brief July 2004.

⁹ MetLife Mature Market Institute. *MetLife Long-Term Care IQ Removing Myths, Reinforcing Realities*. September 2009.

¹⁰ Minnesota Department of Human Services. Aging Initiative: *Project 2030 Baby Boomer Market Research Report* June 1997.

In addition, while many believe that private long-term care insurance plays a major role in financing long-term care, this has not been the case. Long-term care insurance has not achieved any significant penetration among retirees and pre-retirees due in part to this lack of awareness. The Long-Term Care Financing Strategy Group estimated in 2005 that about 8 million long-term care insurance policies were in force or about one in six people over age 65 with an income over \$20,000.¹¹ Policy sales in recent years have remained virtually flat. Consumers that are uninsured for long-term care and unprepared for its associated cost often end up on Medicaid. Medicaid is the largest payer of long-term care services in the country.¹² The sheer size of the baby boom generation poses a major challenge to State and the Federal Governments to sustaining current access to publicly funded long-term care.

In 2005, Congress acted to increase consumer awareness of long-term care by establishing The National Clearinghouse for Long-Term Care Information (Clearinghouse) in the Deficit Reduction Act of 2005 (DRA). Section 6021(d) of the DRA appropriated \$15 million in funding for the Clearinghouse. The goal was to make consumers more aware of the need to plan ahead and to offer information and tools to assist them in planning. The premise behind the Clearinghouse is that preparing consumers for long-term care may reduce dependence on Medicaid and other public sources of financing. Over the last 4 years, ASPE has had a major role in administering this effort in coordination with CMS, the Administration on Aging, the National Governors Association, and individual State governors. The two major components of the Clearinghouse are as follows:

(1) *National Clearinghouse Web site.*—The Administration on Aging (AoA) hosts a Web site (www.longtermcare.gov) that provides consumers with information about how to plan for long-term care. The Web site contains information on public coverage such as Medicare and Medicaid as well as private financing alternatives such as reverse mortgages and long-term care insurance. Consumers can obtain general information about long-term care as well as links to State-specific resources such as local area agencies on aging or State divisions of insurance.

(2) *State-Based Long-Term Care Awareness Campaigns.*—State-based awareness campaigns combine State and Federal resources to reach out directly to consumers. Over the last 4 years, 16 States have launched campaigns, reaching over 20 million households. Each State campaign featured a letter from the Governor, a State-specific informational brochure and included a number of State-specific activities designed to take advantage of local messaging opportunities. Consumers are asked to respond to the mailings by requesting more information by mail, phone or through the internet. The response to these campaigns has exceeded expectations; while direct mail campaigns define success as response rates over 1 percent, these State campaigns have had rates from a low of about 4 percent to a high of over 21 percent.

Much of the consumer material on the Web site and in the State campaigns was designed and tested several years ago. In an effort to improve the quality of the campaign materials, a Technical Expert Panel (TEP) was convened last year to obtain input from a variety of experts with perspectives in social marketing, private insurance marketing, and non-profit communications. The TEP provided a review of the materials and made three major recommendations. They are:

A. *Segment the target market.*—The TEP felt that the age span in our target market was too broad to reach with a single set of materials. They noted, for example, that younger persons did not like the suggestion that they do crossword puzzles to keep their minds active or receiving information about programs and options for which they are decades away from using, such as reverse mortgages. They recommended targeting narrower age groups with greater homogeneity to ensure our messaging remains salient.

B. *Reduce the number of calls to action.*—The TEP felt that the materials contained too many calls to action (9 to 12), even for the segments for which the messaging was relevant. Based on the findings of research by Barry Schwartz,¹³ and Richard Thaler and Cass Sunstein,¹⁴ the TEP noted that people are often over-

¹¹ Long-Term Care Financing Strategy Group. *Index of the Long-Term Care Uninsured*. Washington, DC: Long-Term Care Financing Strategy Group; 2005.

¹² Georgetown University Long-Term Care Financing Project. *National Spending for Long-Term Care Fact Sheet*. February, 2007.

¹³ Schwartz, Barry, *The Paradox of Choice: Why More is Less*. Harpers Collins. New York, NY, 2004.

¹⁴ Thaler, Richard and Cass Sunstein, *Nudge: Improving Decisions About Health, Wealth and Happiness*. Penguin Books: New York, NY, 2008.

whelmed if there are too many options or suggestions, even if they are sympathetic to the overall message.

C. Simplify the message.—The TEP also concluded that we were asking too much of the target market with materials that were too long and too complex. They suggested that we do not try to provide a complete education on the topic but just make an appeal for a limited set of relevant action steps.

The impetus for this new work stems from an extension of Clearinghouse funding via the recently passed Patient Protection and Affordable Care Act. The Clearinghouse was extended and funded for an additional 5 years during which new materials will be needed to continue to increase consumer awareness about long-term care. This project will mainly serve to revise the awareness materials in accordance with the recommendations of the TEP. The contractor will review the Department's current materials, develop a marketing strategy focused on narrower age groups and other segments of the population, design separate materials for each segment, and analyze survey and focus group information in order to make revisions. The collection of information through the survey, the focus groups and other means will be done via a separate ASPE contract with Knowledge Networks.

III. Project Summary

Key Goal: The key goals for this task order are to: (1) develop a market segmentation framework for better communicating with the American public about long-term care by focusing on narrower age groups and other segments, (2) develop materials focused on narrower market segments, and (3) test and refine the new materials to reflect the preferences of each market segment.

Study Design: After a market segmentation framework is developed, consumer awareness materials will be developed for each segment. These materials will be tested in small interactive chats and larger town hall meetings. The data will be collected by Knowledge Networks through a separate task order, will be analyzed in this task order and will be used to revise the materials after each phase to better reflect market segment preferences.

Major Deliverable: This task order has two major deliverables: (1) a market segmentation framework that is focused on specific age groups and other segments and (2) a series of associated consumer awareness materials related to long-term care. The materials will include educational information on long-term care as well as calls to action for individual planning.

Contractor Coordination: The contractor for this project must be willing to coordinate with Knowledge Networks as well as the contractor selected for the task order entitled "Development of a Survey on Long-Term Care Awareness and Planning." It is anticipated that each of the three contractors will designate a liaison that will be responsible for coordinating with the other contractors.

IV. Sample Research Questions

- What are the different segments of our target market population? What information sources are trusted for issues related to retirement and long-term care?
- What kind of information do consumers need to better understand the risks and costs associated with needing long-term care services?
- Are there differences in how segments of the American public use and receive information related to planning for the future in general and long-term care specifically? Are some forms of information and/or media better suited to specific segments?

V. Specification of Tasks

Task 1.0 Post-Award Meeting

Within two (2) weeks of award, the contractor and other relevant staff (including the liaisons for the other task orders) shall meet with the ASPE task order officers to discuss the objectives of the task order and any related issues. The Government anticipates a joint post-award meeting for all three task orders. Specific topics to be discussed include, but are not limited to, purpose and goals of the task order, scope of work, timetable, format of deliverables, and dissemination of findings. The contractor shall prepare a brief memorandum summarizing issues discussed at the post-award meeting. The memorandum is due one (1) week following the meeting (see Appendix A for the Schedule of Deliverables).

Task 2.0 Work Plan

The contractor shall develop a work plan that will guide their activities. The work plan, which will reflect the results of the Post-Award Meeting (Task 1), will serve as a blueprint for the contractor's approach to carrying out task order activities and shall include:

- A strategy for segmenting the target market by extent of readiness for long-term care awareness and planning;
- A process for communicating with the other task order liaisons;
- Potential members of the Technical Expert Panel and date of meeting;
- A timeline for the development of new segment-specific consumer materials;
- A strategy and timeline for testing new materials with consumers; and,
- A delivery schedule.

For each task, the work plan shall describe the approach the contractor shall take, personnel assignments, and target date for completion of specific tasks. The work plan shall be modified as needed as the task order progresses at the discretion of the task order officers. The draft work plan shall be submitted to the task order officers for review within five (5) weeks of contract award. A revised work plan, addressing comments from the task order officers, shall be submitted two (2) weeks later and be considered final upon approval of the task order officers.

Task 3.0 Establish Technical Expert Panel

The contractor shall provide the task order officers with a prioritized list of fifteen (15) candidates with expertise in market segmentation, advertising and designing materials for baby boomers and/or general long-term care and retirement research to serve on a Technical Expert Panel (TEP). The TEP will provide substantive advice regarding technical decisions, review major reports and documents, and be consulted individually and/or collectively throughout the course of the task order (see Task 7, Task 8, Subtask 10.1, and Subtask 12.2). The contractor shall form a TEP of eight (8) experts from the original list of 15 based on consultations and feedback from the task order officers. Non-government members of the TEP will receive an honorarium of \$1,000 and the contractor shall reimburse experts for travel expenses related to their participation. For purposes of bidding, the contractor shall assume that there will be at least six non-local experts who will need to travel to Washington, DC for the TEP meeting. The list of potential members of the TEP shall be submitted to the task order officers eight (8) weeks following contract award. The contractor shall secure agreements for participation from TEP members twelve (12) weeks following contract award.

Task 4.0 Literature Review

The contractor shall conduct a review of the literature and materials in the following three areas:

- Survey research related to the attitudes, opinions and interests of the target population around long-term care in general, and long-term care financing/planning in particular. Of particular interest are surveys of “buyers and non-buyers” of long-term care insurance and surveys related to consumer assessment of long-term care risk.
- Evaluations of major public awareness or social marketing campaigns that have focused on a similar target market and been conducted in the last 7 years. The review shall identify lessons learned or findings that might be useful to the current project. Of particular interest are evaluations of campaigns related to long-term care or to other financial planning-type activities such as advanced care planning or estate planning. The goal of the review is to take advantage of the lessons from previous public campaigns that have been evaluated.
- Current messages and media related to long-term care in general and long-term care financing specifically. The contractor shall identify messages from news organizations, public entities and private industry to members of the target market. It should identify, to the extent possible, existing competing and complementary messages from the major long term-care insurers, advocacy organizations and government agencies. The contractor should use the scan to identify opportunities for new messages such as information gaps or other ongoing activities that can be utilized. Of particular interest is the range of motivational appeals, assumptions about target market financial and issue knowledge, and use of various forms of media.

The draft literature review shall be completed no later than fourteen (14) weeks from award of the contract. The contractor shall submit a final literature review within 2 weeks of receiving comments from the Government.

Task 5.0 Preliminary Market Segmentation Framework

Using the review of literature (Task 4), the contractor shall propose a preliminary conceptual framework for segmenting population aged 40–70 into smaller sub-groups. The purpose of the segmentation is to allow for the development of messages and calls to action that are more relevant to members of each sub-group. The Government anticipates that the initial segmentation factor will be age because long-term care planning changes over the life span. In addition to age, the contractor

shall consider a wide range of demographic and other variables including attitudes, opinions, and interests before recommending a segmentation strategy. The contractor shall present more than one approach to segment the market and should outline the advantages and disadvantages of each approach. The proposed segmentation should be large enough to represent a significant portion of the total target market while small enough to allow for the design of awareness messages and calls to action with a high degree of salience to each segment. The applicability of existing segmentation systems such as Nielsen/PRIZM (consumer lifestyle segmentation) and work by Jeremy Pincus of Forbes Consulting should be considered as part of the development process.

The preliminary market segmentation framework shall be completed no later than eighteen (18) weeks from award of the contract. The Government anticipates that the preliminary framework will be adjusted as data become available from the complementary long-term care awareness projects and will be finalized in Subtask 12.1.

Task 6.0 Marketing Materials Memo

After development of the market segmentation framework (Task 5), the contractor shall draft a memo outlining preliminary content for long-term care planning for each segment. The Government anticipates that content for each segment will combine the following four elements:

- Information/knowledge: information and/or data that encourage each segment to consider a call to action. For example, does the target market need to know how to compute compound interest in order to buy long-term care insurance? Information for each segment should be included based on how it engages the target market in a call for action. This element should include information on risk, types of providers and cost of care.
- Call to action: suggested planning actions for each segment, restricted to the three most significant steps that members of the segment can take now. This element is largely dependent on age. For example, the oldest segment may be asked to learn about reverse mortgages whereas the youngest one will not.
- Motivational appeal: the rationale the target market could consider adopting for answering a call to action. For example individuals used to exerting control over their lives may respond positively to the suggestion that they need to consider long-term care planning to ensure continued control as they require services.
- Delivery: the medium or method used for delivering content. Segments may have different preferred media for information about long-term care. For example, the Department's logo on a direct mail piece may provide issue validation for some segments. Other segments may prefer to receive information through social networking or from peer issue leaders. Content delivery may vary for each market segment but should be held together by similar themes and/or designs.

The contractor shall submit the memo no later than twenty-two (22) weeks from award of contract. The memo shall be considered final upon approval of the task order officers.

Task 7.0 Technical Expert Panel (TEP)

The contractor shall be responsible for making arrangements to convene one in-person meeting of the TEP in Washington, DC. The main purpose of the TEP is to provide feedback on the marketing materials memo (Task 6). However, during the meeting the TEP will also review the literature review (Task 4) and the preliminary market segmentation framework (Task 5).

Arrangements for the meeting will include preparing the agenda, compiling necessary materials, making logistical arrangements, taking minutes, and summarizing proceedings. Agendas and meeting materials shall be submitted to the task order officers twenty-three (23) weeks after contract award for distribution to TEP members. The TEP meeting shall take place no later than twenty-five (25) weeks after contract award. The contractor shall submit a summary that outlines the TEP comments and makes recommendations regarding the need to revise the marketing materials memo no later than twenty-seven (27) weeks after contract award.

Task 8.0 Development of Draft Marketing Materials

Building on the recommendations and comments from the TEP (Task 7), the contractor shall develop new marketing materials. The contractor must have the capability to create and reproduce prototype marketing materials for the various marketing segments as identified in Task 5. The materials shall be developed so that they can be reproduced both in electronic and hard versions. The draft marketing materials shall be developed within thirty-three (33) weeks after contract award. The task order officers may seek feedback and comments from selected members of the TEP.

Task 9.0 Interactive Chats

The contractor shall moderate three (3) sets of three (3) interactive chats with members of the market segments identified in Task 5. The interactive chats will be convened by Knowledge Networks using members of their KnowledgePanel®. The purpose of these chats is to solicit reactions, opinions and ideas related to the draft marketing materials as developed in Task 8. Following each set of chats, the materials will be revised for testing in the next set of chats.

Participants will provide feedback on the content of the materials and suggest ways for improvement. For budget estimation purposes, the contractor should assume nine (9) interactive chats with no more than nine (9) participants in each chat.

Subtask 9.1: First Set

The contractor shall work with Knowledge Networks and the task order officers to schedule the first of three (3) sets of three (3) interactive chats with members of the market segments identified in Task 5. Participants will review the draft materials and provide reactions/comments. The contractor shall moderate the discussions and provide discussion topics when necessary. The contractor shall submit a discussion outline for ensuring that all chats cover the same topics. The discussion outline shall be considered final upon approval of the task order officers and shall be submitted two (2) weeks prior to the chat.

The initial interactive chat shall be conducted no later than thirty-six (36) weeks after contract award. The contractor shall submit a short memo summarizing the discussion and recommending changes to the draft materials. The memo shall be submitted no later than thirty-eight (38) weeks after contract award and shall be considered final upon approval of the task order officers. The contractor shall then revise the materials based on the feedback from the initial chats. The materials should be revised no later than forty (40) weeks from contract award.

Subtask 9.2: Second Set

Using the newly revised materials from Subtask 9.1, the contractor shall again work with Knowledge Networks and the ASPE task order officers to convene a second set of three (3) interactive chats with members of each market segment as identified in Task 5. Participants in each chat will review the revised draft materials and provide reactions/comments. The contractor shall moderate the discussions and provide discussion topics when necessary. The contractor shall submit a discussion outline for ensuring that all chats cover the same topics. The discussion outline shall be considered final upon approval of the task order officers and shall be submitted two (2) weeks prior to the chat.

The second set of interactive chats shall be conducted no later than forty-two (42) weeks after contract award. The contractor shall submit a short memo summarizing the discussion and recommendations for changes to the draft materials. The memo shall be submitted no later than forty-four (44) weeks after contract award and shall be considered final upon approval of the task order officers. The contractor shall then revise the materials based on the feedback from the second set of interactive chats. The materials should be revised no later than forty-six (46) weeks from contract award.

Subtask 9.3: Third Set

Using the newly revised materials from Subtask 9.2, the contractor shall again work with Knowledge Networks and the ASPE task order officers to convene a third set of interactive chats with members of each market segment as identified in Task 5. Participants in each chat will review the revised draft materials and provide reactions/comments. The contractor shall moderate the discussions and provide discussion topics when necessary. The contractor shall submit a discussion outline for ensuring that all chats cover the same topics. The discussion outline shall be considered final upon approval of the task order officers and shall be submitted two (2) weeks prior to the chat.

The third set of interactive chats shall be conducted no later than forty-eight (48) weeks after contract award. The contractor shall then revise the materials based on the feedback from the participants. The materials should be revised no later than fifty (50) weeks from contract award. These revised draft marketing materials shall be considered final upon approval of the task order officers.

Task 10.0 Interactive Town Hall Meetings

The contractor shall moderate on-line interactive town hall meetings on the materials developed in Subtask 9.3. The interactive town halls will be convened by

Knowledge Networks using members of their KnowledgePanel®. The number of town hall meetings will be determined as a result of the preliminary market segmentation framework completed under Task 5. For budget purposes, the contractor should assume six (6) town hall meetings. The Government anticipates that the on-line town hall meetings shall be convened between 50–70 weeks after award of the contract.

Subtask 10.1: Town Hall Content

The town hall meetings will feature a presentation by a moderator followed by informal discussion and instant polling. The presentation shall consist of a description and display of the marketing materials that were developed in Subtask 9.3. The presentation should provide several opportunities for open discussion and instant polling related to the materials. Participants will (a) respond to prototype educational/marketing materials, (b) raise questions and (c) offer responses to instant polls. The contractor shall develop a presentation for each segment that displays the educational materials and polls participants. The presentations shall be developed three (3) weeks before the scheduled town hall meetings. The contractor shall revise the presentations reflecting input and edits from the task order officers and other reviewers designated by the task order officers.

Subtask 10.2: Town Hall Meetings

Each town hall meeting will consist of no more than one hundred (100) participants. Respondents will be selected based on the preliminary market segmentation framework. The contractor shall work with the task order officers and Knowledge Networks to align the selection of the participants with each market segment. The timing of the town hall meetings shall be coordinated between the task order officers, the contractor and Knowledge Networks.

Task 11.0 Analysis of Town Hall Meetings

Using a recording provided by Knowledge Networks, the contractor shall analyze consumer reactions from the town hall meetings. The contractor shall prepare a report that synthesizes how members of each market segment reacted to the revised materials. The report shall include recommendations for changing the consumer materials in accordance with the findings. Analysis of the town hall meetings shall be submitted no later than eight (8) weeks after the last town hall meeting and shall be considered final upon approval of the task order officers.

Task 12.0 Final Deliverables

Subtask 12.1: Final Market Segmentation Framework

The contractor shall finalize the preliminary market segmentation framework developed in Task 5. The final framework shall incorporate any new information that has become available via this project, or other complementary long-term care awareness projects, since the conclusion of Task 5. Of particular interest will be the comments and recommendations of the preliminary framework by the TEP (Task 7).

The final market segmentation framework shall be submitted to the task order officers no later than seventy (70) weeks from contract award. The contractor shall make any recommended changes to the framework (as determined by the task order officers) within two (2) weeks.

Subtask 12.2: Final Revised Materials

The contractor shall revise the final draft materials (from Subtask 9.3) for each segment (Task 5) based on the analysis of the town hall meetings (Task 11) and any feedback from the task order officers and any members of the TEP (Task 3) (as solicited by the task order officers). These materials are not intended to be the final “publicly distributed” materials; rather, they are intended to be the final materials (both in terms of content and camera-ready “look and feel”) for this task order. It is expected that the materials will be revised, as necessary, when they are to be distributed to the public during future awareness efforts.

The final revised materials shall be submitted to the task order officers no later than seventy-four (74) weeks from the contract award. The contractor shall make any recommended changes to the materials (as determined by the task order officers) within four (4) weeks.

Subtask 12.3: Draft Task Order Summary

The contractor shall submit a draft task order summary that includes an overview of all activities with timelines. The draft summary should be no more than twenty (20) pages and, in addition to the overview, should contain detailed summaries of the following:

- the literature review;
- the materials redesign process; and
- the interactive discussions (chats and town hall).

The draft task order summary shall be submitted to the task order officers no later than seventy-eight (78) weeks from the contract award.

Subtask 12.4: Final Task Order Summary

The contractor shall submit a revised task order summary that incorporates comments and edits from the task order officers no later than eighty-two (82) weeks after contract award. The final market segmentation framework (Subtask 12.1) and the final revised materials (Xeroxed copies of Subtask 12.2) shall be added to the end of the final task order summary as appendices for purposes of governmental archiving. The entire task order summary will be considered final upon approval of the task order officers.

Task 13.0 Monthly Progress Reports and Interim Meetings*Subtask 13.1: Monthly Progress Reports*

The contractor shall submit monthly administrative progress reports outlining all work accomplished during the previous month. At a minimum, such reports shall cover the following items:

- discussion of the progress in accomplishing the tasks in this task order;
- activities anticipated during the upcoming reporting period; and
- statement of actual costs incurred by task relative to budgeted costs per task.

Monthly reports are due the first week of every month following the approval of the work plan and shall be sent by the contractor directly to the task order officers via e-mail.

Subtask 13.2: Interim Meetings

The contractor and task order officers shall also have interim meetings (in-person or via teleconference) as deemed necessary, but no fewer than two, by the task order officers to discuss issues that need input or approval. It is expected that the two mandatory interim meetings shall be scheduled to update HHS and other Federal Government officials on the (1) development of materials before the interactive chats and (2) the preliminary analysis from the town hall meetings. The timing of these meetings shall be determined by the task order officers.

SECTION D. CONTRACT CLAUSES**Section 508 Compliance**

The final report deliverable must comply with the Department of Health and Human Services Section 508 Compliance Requirements.

This language is applicable to Statements of Work (SOW) generated by the Department of Health and Human Services (HHS) that require a contractor or consultant to (1) produce content in any format that could be placed on a Department-owned or Department-funded Web site; or (2) write, create or produce any communications materials intended for public or internal use; to include reports, documents, charts, posters, presentations (such as Microsoft PowerPoint) or video material that could be placed on a Department-owned or Department-funded Web site.

Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d) requires Federal agencies to purchase electronic and information technologies (EIT) that meet specific accessibility standards. This law helps to ensure that Federal employees with disabilities have access to, and use of, the information and data they need to do their jobs. Furthermore, this law ensures that members of the public with disabilities have the ability to access Government information and services.

There are three regulations addressing the requirements detailed in Section 508. The Section 508 technical and functional standards are codified at 36 CFR Part 1194 and may be accessed through the Access Board's Web site at <http://www.access-board.gov>. The second regulation issued to implement Section 508 is the Federal Acquisition Regulation (FAR). FAR Part 39.2 requires that agency acquisi-

tions of Electronic and Information Technology (EIT) comply with the Access Board's standards. The entire FAR is found at Chapter 1 of the Code of Federal Register (CFR) Title 48, located at <http://www.acquisition.gov>. The FAR rule implementing Section 508 can be found at <http://www.section508.gov>. The third applicable regulation is the HHS Acquisition Regulation (HHSAR).

Regardless of format, all Web content or communications materials produced for publication on or delivery via HHS Web sites—including text, audio or video—must conform to applicable Section 508 standards to allow Federal employees and members of the public with disabilities to access information that is comparable to information provided to persons without disabilities. All contractors (including sub-contractors) or consultants responsible for preparing or posting content intended for use on an HHS-funded or HHS-managed Web site must comply with applicable Section 508 accessibility standards, and where applicable, those set forth in the referenced policy or standards documents below. Remediation of any materials that do not comply with the applicable provisions of 36 CFR Part 1194 as set forth in the SOW or PWS, shall be the responsibility of the contractor or consultant retained to produce the Web-suitable content or communications material.

The following Section 508 provisions apply to the content or communications material identified in this SOW or PWS: Access Board Final Rule “36 CFR 1194.22(a)-(p).”

SECTION E. CONTRACT DOCUMENTS

E.1. Schedule of Deliverables

Task	Deliverable	Date Due in Weeks
Task 1	Post Award Meeting	Week 2
	Post Award Summary	Week 3
Task 2	Work Plan	Week 5
	Revised Work Plan	Week 7
Task 3	Establish Technical Expert Panel	Week 8
Task 4	Literature Review	Week 14
Task 5	Preliminary Market Segmentation Framework	Week 18
Task 6	Marketing Materials Memo	Week 22
Task 7	Technical Expert Panel	Week 25
	Summary of TEP Meeting	Week 27
Task 8	Development of Marketing Materials	Week 33
Task 9	Interactive Chats	
	Subtask 9.1:	
	Discussion Outline	Week 34
	Initial Interactive Chats	Week 36
	Initial Interactive Chat Memo	Week 38
	Revised Materials	Week 40
	Subtask 9.2:	
	Discussion Outline	Week 40
	Second Interactive Chats	Week 42
	Second Interactive Chat Memo	Week 44
	Revised Materials	Week 46
	Subtask 9.3:	
	Discussion Outline	Week 46
	Third Interactive Chats	Week 48
	Revised Materials	Week 50
Task 10	Interactive Town Hall Meetings	
	Subtask 10.1: Town Hall Content	3 Weeks before Subtask 10.2
	Subtask 10.2: Town Hall Meetings	Weeks 50–70
Task 11	Analysis of Town Hall Meetings	8 Weeks after Subtask 10.2
Task 12	Final Deliverables	
	Subtask 12.1: Final Market Segmentation Framework	Week 70
	Subtask 12.2: Final Redesigned Marketing Materials	Week 74
	Subtask 12.3: Draft Task Order Summary	Week 78
	Subtask 12.4: Final Task Order Summary	Week 82
Task 13	Monthly Progress Reports and Interim Meetings	
	Subtask 13.1: Monthly Progress Reports	Monthly
	Subtask 13.2: Interim Meetings	As Needed

E.2. Quality Assurance Surveillance Plan

Required Services/tasks	Performance Standards	Method of Surveillance (Quality Assurance)	Standard to be Met/Allowable Deviation
Task 5 Market Segmentation Framework.	Contractor develops a clear market segmentation framework that links development and analysis of response data to research questions.	Task order officers will work closely with contractor.	Market Segmentation framework is completed in a timely fashion so as to guide subsequent tasks.
Task 6 Development of Marketing Materials.	Contractor develops draft marketing materials from information gathered in earlier tasks.	Task order officers will work with contractor (and any subcontractors) on the development.	Draft marketing materials are ready for dissemination to the Technical Expert Panel on deadline outlined in contract.
Task 9 Interactive Chats.	Contractor moderates the different sets of interactive chats and analyzes the information that comes from them.	Task order officers will work closely with contractor and review transcripts of all chats.	Revisions to the draft marketing materials are made after each set of interactive chats.
Task 11 Analysis of Town Hall Meetings.	Contractor analyzes the information that comes from the different sets of interactive town hall meetings.	Task order officers will work closely with contractor.	A set of revised draft marketing materials for each identified market segment are produced.
Task 12 Final Deliverables.	Contractor develops a final market segmentation framework and a final set of marketing materials for all the identified segments and produces a final report.	Task order officers will review drafts of all Final Deliverables.	Contractor delivers the three distinct final deliverables to the task order officer on schedule and of acceptable quality.
Task 12 Monthly Progress Reports.	Contractor keeps task order officers informed as to unforeseen problems and/or necessary changes to work plan.	Task order officers will attend all monthly and interim meetings and review all progress reports.	Contractor informs task order officers of issues that impact schedule of deliverables or costs associated with the contract.

E.3. Travel Costs

Travel costs, shall be included in the Firm Fixed Price and will be evaluated in accordance with Federal per diem rates and Federal Travel Regulation (FTR). All travel shall be approved, by the COTR, prior to commencement of travel.

E.4. Rights in Data—Advance Approval for Dissemination of Project Information Prior to Contract Completion

The Contractor (including any subcontractors or consultants) agrees not to disclose, verbally or in writing, information pertaining to the results or findings of work (including data base files, analyses, draft or final papers and reports) for the period of an individual delivery order under this contract without obtaining prior written approval of the task order officers. The Contractor must request approval in advance (minimum 21 days prior to release) and in writing, specifying: who or what is generating the request for advance information; when and how project results/information would be released; and what information would be released. Failure to receive response to the task order officers does not constitute approval for releasing information.

E.5. Specifications for the Delivery of Digital Copies of Reports

In addition to the printed copies required under the contract, digital copies of the reports shall be delivered on media readable by Windows 9x programs. The text, tables, and any charts or other graphics shall be organized and formatted as described in the following paragraphs.

Text may be formatted in any of the commonly available word processing programs marketed by the IBM®, Corel®, or Microsoft® corporations. Lengthy documents (greater than 500 Kb) should be divided into several parts and a separate file should be provided for each part. Lengthy files (greater than 200 Kb) should be avoided if possible.

The title page, table of contents, and other front matter shall be in a separate file. File names should contain consecutive numbers that correspond to the numerical labels used in the printed version. For example, Chapter 4, Figure 2 can be ren-

dered as C4F2.gif. Suffixes shall be those used by the software manufacturer or follow the usual industry conventions, e.g., doc, wpd, xls, gif, jpg, etc. Where compatibility with earlier versions of the software is in doubt, files shall be delivered in the penultimate version of the software.

Tables and tabular material shall not be converted into graphical images, but be included with the word processing files or delivered as spreadsheet files.

Graphic figures such as bar and line charts, diagrams, and other drawings shall be delivered in the GIF (Graphics Interchange Format) or the JPEG (Joint Photographic Experts Group) format. Even though the graphical elements may have been merged with the text to form a single file for printing purposes, each graphical image (figure) shall be delivered as a separate file and must not be embedded in a word processing, spreadsheet, slide show or other composite file.

Questions regarding the interpretation of these specifications may be directed to Brian Sinclair-James, ASPE Coordinator of Information Dissemination, at (202) 401-6127.

SECTION F. CONTRACT ADMINISTRATION

F.1. Invoicing and Payment

One original voucher complete with all required back-up documentation shall be submitted to the Contract Specialist and addressed to:

Division of Acquisition Management, SAS/PSC
Parklawn Building, Room 5C-18
5600 Fishers Lane
Rockville, MD 20857
Contract Number: HHSP23320100022WI
Task Order Number: HHSP23337001T

One copy of the voucher with copies of all required back-up documentation shall be emailed to *PSC_EAPPROVAL.CPMT@PSC.HHS.GOV* or they may be submitted to:

PSC/FMS/DFO Commercial Payments Section
Parklawn Building, Room 16A-12
5600 Fishers Lane
Rockville, MD 20857

The contractor shall list the COTR name and phone number on the face page of the voucher.

One copy of the voucher with copies of all required back-up documentation shall be emailed to the COTR (the cover page of all invoices must show the Contract Number, and the Government COTR's name and telephone number) or they may be submitted to:

Office of the Assistant Secretary for Planning and Evaluation
U.S. Dept. of Health and Human Services
Attn: Hunter McKay and Sam Shipley
Hubert H. Humphrey Bld., Room 424E
200 Independence Ave. SW
Washington, DC 20201
(202) 690-6443

All calls concerning contract payments shall be directed to the general help line for contract payments on (301) 443-6766.

F.2. Contracting Officer's Technical Representative (COTR) Appointment and Authority

(a) Performance of work under this contract must be subject to the technical direction of the COTR identified above, or a representative designated in writing. The term "technical direction" includes, without limitation, direction to the Contractor that directs or redirects the labor effort, shifts the work between work areas or locations, fills in details and otherwise serves to ensure that tasks outlined in the work statement are accomplished satisfactorily.

(b) Technical direction must be within the scope of the specification(s)/work statement.

(c) The COTR does **not** have authority to issue technical direction that:

- (1) Constitutes a change of assignment or additional work outside the specification(s)/Statement of Work;
- (2) Constitutes a change as defined in the clause entitled "Changes";
- (3) In any manner causes an increase or decrease in the Contract Price, or the time required for Contract Performance;

- (4) Changes any of the terms, conditions, or specification(s)/Work Statement of the Contract;
- (5) Interferes with the Contractor's right to perform under the terms and conditions of the Contract; or
- (6) Directs, supervises, or otherwise controls the actions of the Contractor's employees.

(d) Technical direction may be oral or in writing. The COTR shall confirm oral direction in writing within 5 work days, with a copy to the Contracting Officer.

(e) The Contractor shall proceed promptly with performance resulting from the technical direction issued by the COTR. If, in the opinion of the Contractor, any direction of the COTR, or his/her designee, falls within the limitations in (c), above, the Contractor shall immediately notify the Contracting Officer no later than the beginning of the next Government work day.

(f) Failure of the Contractor and the Contracting Officer to agree that technical direction is within the scope of the Contract shall be subject to the terms of the clause entitled "Disputes."

F.3. Contracting Officer's Technical Representative (COTR)

The COTR is responsible for the technical requirements covered by this Contract, as contemplated by Section F.2., hereof, will be designated by separate correspondence.

F.4. Contracting Officer

Contracting Officer (CO): The CO has the overall responsibility for the administration of this Contract. The CO is the only person authorized to take actions on behalf of the Government to: amend, modify, or deviate from the Contract terms, conditions, requirements, specifications, details and/or delivery schedules; make final decisions on disputed deductions from Contract payments for non-performance or unsatisfactory performance; terminate the Contract for convenience or default; issue final decisions regarding Contract questions or matters under dispute. Delegation of other responsibilities may be made to authorized representatives.

[Whereupon, at 12 p.m., the hearing was adjourned.]